

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 19, 2021

Administrator Victory Health & Rehabilitation Center 512 49th Avenue North Minneapolis, MN 55430

RE: CCN: 245544

Cycle Start Date: December 2, 2021

Dear Administrator:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On December 2, 2021, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 3, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 3, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 3, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for

Victory Health & Rehabilitation Center December 19, 2021 Page 2

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by January 3, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Victory Health & Rehabilitation Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 3, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same

Victory Health & Rehabilitation Center December 19, 2021 Page 3

deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an E tag), i.e., the plan of correction should be directed to:

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us

Office: (651) 245-8094

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE

Victory Health & Rehabilitation Center December 19, 2021 Page 4 SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 2, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

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| LABORATOR) | / DIRECTOR'S OR PROVID | DER/SUPPLIER REPRESENTATIVE'S SIGN | NATURE | TITLE | | | (X6) DATE |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

12/27/2021

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI IER/CLIA

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| F 580 | social worker (SW to the emergency was placed on obswith a chief complete thrive. During an interview LPN-B stated R29 medications on 11 provider. R29 was concerns regardin verbalized they we transferred to the IDuring an interview licensed practical observed R29 nea 11/30/21, at approwhen arriving for had already left for his shift, however, regarding why R29 During an interview physician assistancall notes dictated was at the hospita LPN-B called to rethe resident, did not stated they learned chart review on 11 preparing for a vis expected to notify when a resident wand further verbali | w on 12/1/21, at 3:18 p.m. 1)-A stated R29 was transferred department on 11/22/21, and servation status at the hospital aint of vertigo and failure to w on 11/30/21, at 1:35 p.m. refused to take any 1/22/21, and had notified the not aware of any other g R29 during their shift and ere not aware R29 was | F 58 | ensure compliance. Audit results will be reviewed Administrator and the Admin take the audit results to QAP and recommendation. Compliance: 1/10/ 2022 | istrator will | |

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| F 580 | hospitalization. During an interview director of nursing (why R29 was hospi up to R29 going to R28's medical recording R29 was hospitalized notification. The DC to notify providers a Facility policy titled Condition or Status facility would promp resident's medical condition/status. ADL Care Provided CFR(s): 483.24(a)(2) A resout activities of daily services to maintain personal and oral harmonic personal and oral harmonic REQUIREMENTS. Based on observative review, the facility fangiene was provid who was dependent | on 12/2/21, at 10:10 a.m. the (DON) stated she did not know talized or the events leading the hospital. The DON verified rd lacked indication of why ed or subsequent provider DN stated she expected staff and document the notification. A Change in a Resident's (undated), indicated the otly notify the physician of a change or change in for Dependent Residents 2) ident who is unable to carry y living receives the necessary in good nutrition, grooming, and | F 58 | R 28 ADL care plan and resident preferences was reviewed and upon as needed. R 28 refusals will be rein the electronic medical record. R | ecorded 28 has | |
| | R28 had diagnoses arthritis (causes pa | ecord dated 12/2/21, indicated which included rheumatoid in, swelling, stiffness, and loss and chronic pain syndrome. | | since been placed on hospice servand will have a follow up visit with facility social worker to assess resistisfaction of ADL cares. R 28's response will be recorded in the elemedical record. Current residents receive total care were interviewed their care plan was reviewed and upon the side of the side o | the ident ectronic who I and | |

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| F 677 | R28's quarterly Mi 10/27/21, indicate and had no docum was totally depend transfers, toilet us had impairments of extremities and was R28's care plan day an ADL self-care of knee amputations the spine connects weakness, and rhidirected to provide cares, assist with Review of R28's A 11/30/21, indicated 11/30/21, staff doccompleted for 16 on documented rehospitalized on 11. Review of R28's A 12/2/21, indicated was completed for 16 on documented rehospitalized on 11. Review of R28's A 12/2/21, indicated was completed for 16 on documented rehospitalized on 11. Review of R28's A 12/2/21, indicated was completed for were no documented rehospitalized on 11. Review of R28's A 12/2/21, indicated was completed for were no documented rehospitalized on 11. Review of R28's A 12/2/21, indicated was completed for the were no documented rehospitalized on 11. Review of R28's A 12/2/21, indicated was completed for the were no documented rehospitalized on 11. Review of R28's A 12/2/21, indicated was completed for the were no documented rehospitalized on 11. Review of R28's A 12/2/21, indicated was completed for the were no documented rehospitalized on 11. Review of R28's A 12/2/21, indicated was completed for the were no documented rehospitalized on 11. | nimum Data Set (MDS) dated d R28 was cognitively intact nented rejection of care. R28 dent of two staff for bed mobility, e, and personal hygiene. R28 of both upper and lower as always incontinent of bowel. Atted 5/2/21, identified R28 had deficit related to bilateral above, a sacral wound (area where is to the lower half of the body), eumatoid arthritis. Staff were exassistance with all hygiene toileting, bathing, and dressing. DL Task Record dated defrom 11/1/21, through cumented hygiene was of 87 opportunities. There were fusals and R28 was /24/21. DL Task Record Record dated from 12/1/21, staff documented from 12/1/21, staff documented from 12/1/21, staff documented from 10 3 opportunities. There | F6 | as needed. There has bee ADL care concerns voiced residents or resident representative residents will be assembled. August heir ADL ability will be care interventions implemented. Nursing staff will be in-serv ADL Support Policy and Preemphasis on item #4 to assemble the cause of the refusal and re-approach. Director of nursing and/or coresponsible for compliance Audits on ADL care and do refusal/reapproach for care where the august will be reviewed Administrator and the Admit take the audit results to QA and recommendation. | from existing sentatives. Sessed and explanned and iced on the ocedure with sess to identify d to designee is a cumentation of exill begin 2x weeks then oce. Sed by the inistrator will | |

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| F 677 | R28 laying in bed a nursing assistant (N care or oral care the NA-A stated the ever oral cares and nail needed to be cut or underneath. During an interview licensed practical needed to be cut or underneath. During an interview licensed practical needed to be cut or underneath. During an interview licensed practical needed to five the care R2 further stated she shails. During an observat R28's fingernails relong with browning/ During an interview stated no one had oprovided oral cares sometime the previperviously brushed able to do it on her would like to have her cares provided. During an interview assistant director or was unaware oral of R28. During an interview director of nursing (1) | ion on 11/30/21, at 9:41 a.m. nd provided a bed bath by NA)-A. NA-A did not offer nail roughout the observation. ening or night shift can provide care. Further, R28's long nails cleaned because of dirt on 11/30/21, at 2:28 p.m. urse (LPN)-C stated it was the sing assistants to provide ADL resident's care plan directed required every day. LPN-C aw dirt build up under R28's ion on 12/1/21, at 9:39 a.m. mained roughly two inches black residue underneath. If on 12/1/21, at 10:00 a.m. R28 cleaned her fingernails or for many days; maybe ous week. R28 stated she her teeth daily when she was own. R28 expressed she her nails cleaned and oral on 12/1/21, at 1:45 p.m. the finursing (ADON) stated she har serious were not provided to the following cares. The DON stated | F 6 | 777 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPI IER/CLIA

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | IPLE CONSTRUCTION NG | | E SURVEY PLETED |
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| | | 245544 | B. WING _ | | | C 02/2021 |
| | PROVIDER OR SUPPLIER | LITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430 | 12/ | 02/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 686 SS=G | hygiene care and dexpectation was for completed every shatted she felt there complete cares, but did not always want. The DON confirmed were long. Facility policy titled (ADL's) (undated) cunable to carry out receive services to grooming, and pers. Treatment/Svcs to CFR(s): 483.25(b)(1) Press. Based on the compresident, the facility (i) A resident receive professional standar pressure ulcers and ulcers unless the indemonstrates that the (ii) A resident with professional standary treatment with professional standary treatme | should provide daily personally ocument refusals. Her personal hygiene cares to be lift and as needed. The DON was enough staff to the facility culture was nurses to help nursing assistants. It she knew R28's fingernails Activities of Daily Living lirected residents who were ADLs independently would maintain good nutrition, onal and oral hygiene. Prevent/Heal Pressure Ulcer 1)(i)(ii) egrity sure ulcers. Irehensive assessment of a must ensure thates care, consistent with added to a most develop pressure dividual's clinical condition hey were unavoidable; and pressure ulcers receives at and services, consistent andards of practice, to revent infection and prevent | F 68 | | weekly Braden | 1/10/22 |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE: AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING (X2) MULTIPLE CONSTRUCTION (X3) DATE: COMPI | | SURVEY PLETED | | | | | |
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| | | 245544 | B. WING | | | () 12/(|) 2/2021 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STR | EET ADDRESS, CITY, STATE, ZIP CODE | | <i>32,</i> 232 : |
| | | | | | 49TH AVENUE NORTH | | |
| VICTORY | / HEALTH & REHABIL | ITATION CENTER | | MINNEAPOLIS, MN 55430 | | | |
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| F 686 | Continued From pa | ge 9 | F 6 | 86 | | | |
| F 686 | the risk of complicatulcer for 1 of 3 reside pressure ulcers. The R28 who had a worulcer. Findings include: Pressure Ulcer Deficiency Stage IV Tissue loss with expressure is usually firmand or soft in textuan in color, and matissue is usually firmand wound and offer wound), may be presundermining (passister of the skin) R28's Admission Reressurface of the skin) R28's diagnoses includer of sacral region connects to the low absence of right and R28's quarterly Min 10/27/21, indicated and had no docume was totally dependent mobility, transfers, a impairment to both and was always incompleted. | dents (R28) reviewed for e resulted in actual harm for sening stage IV pressure dents (Dead tissue that is re, usually black, brown, or any appear scab-like. Eschar anly adherent to the base of en the sides/edges of the esent. It often includes ardly visible wound margins) ageways underneath the | F6 | | along with a comprehensive skin assessment. The care plan was reand updated as needed. The MD was updated that wound documentation inconsistent for November 2021 and MD response will be recorded in the resident medical record. All other residents who have wounds were assessed and weekly documentation recorded and their care plans were reviewed and updated as needed, residents identified with wounds will weekly wound assessments and the pressure care plan initiated and interventions implemented. Nursing staff were in-serviced on the Pressure Ulcer Treatment policy will emphasis on weekly documentation prompt notification to the physician resident refusals of treatment and following treatment orders for place of product etc. Nurse aides were all in-serviced on the importance of turn and repositioning to alleviate pressulcer injury. Daily skin assessments be implemented as needed for high residents and a dedicated nurse will assigned for completion of daily wo care. Director of nursing and/or designed responsible for compliance. Audits on weekly wound care, documentation and turning and repositioning will begin 2x wk for 2 weekly x 2 weeks then monthly to ecompliance. | rill be i was d the e on Future I have eir ne the and on ement so rning ure is will in risk II be bund e is weeks, | |
| | were present upon | admission. Several treatments included pressure reducing | | | Audit results will be reviewed by the Administrator and the Administrator take the audit results to QAPI for re | r will | |

| AND DIAN OF CODDECTION IDENTIFICATION NUMBER: | | | TIPLE CONSTRUCTION ING | CON | (X3) DATE SURVEY COMPLETED | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE |
| F 686 | indicated R28 was bed mobility, dressi hygiene. The CAA fa total assist of two to transfer Further, assistance of two s bed every two hour R28's care plan dat stage IV pressure uschium (lower backischium. The care puschium. The care puschium include assisting include assessments and puschium assessments and puschium assessments and puschium include assisting R28's care plan was include assisting R28's care plan was include assisting R28's order Summindicated staff were protocol, and "may day and an addition break in the morning was to be reposition weekly skin checks morning. R28's worning. | sessment (CAA) dated 5/7/21, totally dependent of staff for ng, toilet use, and personal rurther indicated R28 required staff, with the use of hoyer lift R28 required extensive taff to turn and reposition in s and as necessary. The definition of the hip bone, and left olan further identified R28 had elop additional pressure ulcers nee, immobility, and are plan included several ing to conduct weekly skin provide wound care per orders. It is revised on 12/2/21, to 28 to sit up in tilt-in-space ressure reducing cushion for s not to exceed two hours of | F 6 | and recommendation. | | |
| | from the wound bed Vashe (wound clea | ound healing) were removed d. Saturate 4 x 4 gauze with nser). The saturated gauze red in R28's wound beds and | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | | | |
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| | PROVIDER OR SUPPLIER / HEALTH & REHABII | LITATION CENTER | | STREET ADDRESS, CITY, STATE, Z 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430 | IP CODE | 12/ | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | TION SHOULD THE APPROPI | BE | (X5) COMPLETION DATE |
| F 686 | minutes. Remove (alginate. Place a formorning. An Interdisciplinary dated 12/1/21, at 7 hospitalized from 1 severe sepsis secon wound abscess (confection) and osteon was under observa 11/24/21, related to R28's Wound Physmedical doctor (ME the following: R28's stage IV sameasured 3.5 centrom, with underminity o'clock position. The granulation (new the fascia (thin casing the holds muscle in-plate exudate (clear, thin stage IV pressure of the measured 1.0 cm. abnormal granulation margins. R28's stagright ischium meas cm with 100 percer Recommendations and repositioning poe up for two hours after a two-hour breather the service of R28's Norevealed no transference of of R28's Norevea | and allow to sit for five gauze) and place silver am boarder dressing in the team (IDT) progress note and boarder dressing in the team (IDT) progress note and to be a decubitus sacral oblection of puss related to boay literature and to be a decubitus sacral oblection of puss related to boay literature and to be a decubitus sacral oblection of puss related to boay literature and to chest pain. Ician Progress Note written by D)-C dated 11/18/21, revealed cral pressure wound ameters (cm.) x 3.0 cm. x 2.0 mg of 5.0 cm. at the three wound had 80 percent asue), 20 percent muscle and of connective tissue which ace), and moderate serous and watery fluid). R28's wound to her left ischium and to her left ischium and to her ured 0.8 cm. x 1.5 cm with the present within the wound are facility protocol. R28 may and their chair and one hour | F6 | 686 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | CONSTRUCTION | СОМ | E SURVEY PLETED |
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| | PROVIDER OR SUPPLIER | | | 51 | REET ADDRESS, CITY, STATE, ZIP CODE 2 49TH AVENUE NORTH INNEAPOLIS, MN 55430 | 1 2/ | <i>52/2021</i> |
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| F 686 | were no document Review of R28's Drevealed no transf documented for 2 no documented re Review of R28's Wontes revealed: - 11/19/21, at 3:50 turning and repositioned for 2 no additional document of R2 no additional docum | recember 2021 Task Record, erring/bed mobility was not of 3 opportunities. There were fusals. Veekly Skin Check Progress p.m. indicated R28 was on a tioning program and had a e progress note lacked 8's wound. cumentation was provided, or skin assessments on and 11/22/21. us observation conducted on 0 a.m. to 11:43 a.m. R28 was flat on her back, in bed, with a of her bed. R28's eyes were as noted to be moaning and for help. At 10:30 a.m., R28 ch." At 11:43 a.m., R28 called ated she had pain. At 11:44 ctical nurse (LPN)-C was dvised R28 had not been the continuous observation. LPN-C stated she would notify t. Throughout the observation, 28's room, nor responded to ng out periodically. Three hours | F 6 | 86 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
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| _ | PROVIDER OR SUPPLIER | LITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CO 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430 | • | |
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| F 686 | completely saturate which also soaked product and the she was also observed electrocardiogram (which were remove Zoll electrodes mussince her emergend 11/24/21. LPN-B rethe sacral, right, an wounds. LPN-B the Vashe solution on R28's sacral and rigwounds. The gauze with Vashe solution the gauze was remalginate to R28's sapressure wounds. Tout round and rough did not cover the erwound. LPN-B then foam dressings. Im dressing change LF aware the gauze new Vashe solution or the needed to cover the During an interview assistant director of started a performar wound care and asconcerns regarding assessed, staff role providing wound caprovider. The ADOI assessed by a woushe fell off the list to | ed with bloody red drainage through to R28's incontinence eet below her. Further, R28 to have four Zoll (EKG) electrodes on her backed by LPN-B. LPN-B stated the st had been on R28's backed department visit on moved the old dressing from defit ischium pressure on poured a small amount of gauze and placed the gauze on ght and left ischium pressure was not completely saturated. After roughly five minutes, oved and LPN-B applied silver acral, right, and left ischium The piece silver alginate was hly 1.5 inches in diameter and natire wound bed of the sacral a covered R28's wounds with a mediately following the PN-B stated she was not eeded to be saturated with ne silver alginate dressing | F 6 | 86 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION ING | | | E SURVEY PLETED |
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| F 686 | the director of nursing pactral and right and wounds. The ADON her left side and rer product. The DON had a large copious non-odorous drainathrough the dressin outside of the sacra Vashe soaked gauz five minutes. The Dand inserted silver and inserted silver and inserted silver and bed where undermithen applied a foam. During an interview director of nursing (observed R28's dreappeared wound can ordered. She confir dressing did not contact and fluing R28's dressing and product. The DON obloody discharge and lacked granulation today which was not today which wa | ion on 12/1/21, at 10:00 a.m. ng (DON) and assistant provided wound care to R28's defit ischium pressure. It is assisted R28 to reposition to moved an incontinence are moved the dressings which amount of yellow/brown age with blood which soaked g. The DON cleansed the all pressure wound and applied the to R28's wound beds for to R28's wound beds for to R28's wounds. It is a solution of the poon the pauze alignate into R28's wounds. It is not cover the entire wound ning was located. The DON | F 6 | 686 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | PROVIDER OR SUPPLIER | LITATION CENTER | | STREET ADDRESS, CITY, STATE, Z 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430 | <u> </u> | /UZ/ZUZ I |
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| F 686 | stated staff were no bandages became changed. During an observat MD-C, the ADON, a care to R28. LPN-E her left side. R28 e had facial grimacin incontinence product R28's old dressing right and left ischiu small amount of lig on her incontinence noted on R28's skii sacral wound. The the skin with wound R28's wounds and alginate were noted told the ADON and applicator to asses pieces of silver alginserted Vashe soabeds for five minute gauze and completed. | age 15 of reporting to the nurse when soiled and needed to be sion on 12/2/21, at 12:00 p.m. and LPN-D provided wound assisted R28 reposition to expressed pain to MD-C and g. The ADON removed R28's ct and subsequently removed located on the sacrum and m pressure wounds. R28 had hit brown colored stool noted a product. Stool was also in roughly three inches from the ADON proceeded to cleanse dicleanser. MD-C assessed additional pieces of silver d in the sacral wound. MD-C LPN-D to use a cotton tipped in the wound and ensure all mate were removed. MD-C aked gauze into R28's wound es. MD-C hen removed the rely covered R28's pressure alginate. The wounds were | F 6 | | <u> </u> | |
| | then covered with a stated to the ADON piece of alginate we covered the entire healing. MD-C also completely. Immediately followinterviewed and state deteriorated from wounds two weeks ulcer and measure | a foam dressing. MD-C then I and LPN-D to ensure a full as used so it completed wound bed to promote proper instructed staff to offload R28 and the observation, MD-C was ated R28's sacral wound had when she had assessed R28's ago. R28's sacral pressure ments increased in length and eling. MD-C attributed | | | | |

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| | PROVIDER OR SUPPLIER / HEALTH & REHABI | LITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIF 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430 | | |
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| F 686 | hours. MD-C stated deterioration include continuity of wound MD-C stated during in her incontinence on R28's skin when MD-C stated she ereposition R28 ever wheelchair cushior care, and change of A subsequent Wouwritten by MD-C da following: R28's stage IV sameasured 3.5 cm. serous excaudate slough (dead tissue Further, the wound measured 5.5 cm. at the nine at the 12 o'clock point had "deteriorated" R28's wound was a devitalized tissue (cm. Facility policy titled (undated) directed pressure injuries a injuries. Staff were plan and assess for resident, pressure | g to not being fully being repositioned every two d the reasons for wound led: need to offload the wound, d care, and incontinence care. g her visit today, R28 had stool product and staff left the stool n wound care was provided. Expected the facility to ry two hours, provide R28 and, provide good incontinence dressings immediately if soiled. In Progress Note and Physician Progress Note and Physician Progress Note and 12/2/21, revealed the acral pressure wound at 4.0 cm. x 1.5 cm. Moderate was noted with 10 percent led and 90 percent granulation. In had undermining which at the three o'clock position, o'clock position, and 7.5 cm. osition. R28's sacral wound since her last visit on 11/18/21. Idebrided of 1.4 cm. of non-viable) at a depth of 1.6 Pressure Injury Treatment to provide care of existing and the prevention of additional to review the residents care or any special needs of the injury care, current support | F6 | 86 | | |
| F 689 SS=D | surfaces, and statu Free of Accident H CFR(s): 483.25(d)(| azards/Supervision/Devices | F6 | 89 | | 1/10/22 |

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| NAME OF I | PROVIDER OR SUPPLIER | | | ST | TREET ADDRESS, CITY, STATE, ZIP CODE | | 7 |
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| VICTORY | / HEALTH & REHABI | LITATION CENTER | | | INNEAPOLIS, MN 55430 | | |
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| F 689 | Continued From pa | age 17 | F 6 | 89 | | | |
| | as free of accident §483.25(d)(2)Each supervision and as accidents. This REQUIREME by: Based on interview facility failed to ensin accordance with practice to reduce accident hazards f was administered Findings include: R28's Admission F R28's diagnoses ir (inflammation of lu respiratory failure. R28's Order Summ directed staff to ap into both of R28's of R28's care plan da received oxygen the exchange and dire at I liter per minute Review of R28's T (TAR) dated 11/30. | resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent. NT is not met as evidenced and acceptable standards of the likelihood of potential or 1 of 1 resident (R28) who oxygen therapy. Record dated 12/2/21, indicated accluded pneumonitis ang tissue) and chronic mary Report dated 11/30/21, ply a small amount of Vaseline nostrils twice daily for dryness. Atted 9/17/21, indicated R28 arrapy related to ineffective gas cted staff to administer oxygen | | | MD was contacted and Vaseline of R 28 was discontinued. No adverse effects were experienced during us this petroleum agent. All other reside who receive oxygen therapy orders reviewed for petroleum agent use at their care plans were updated as not reviewed and no orders for petroleum based products will be utilized. The will be contacted for residents who experience nostril dryness for alternation of oxygen therapy and/or administer humidified oxygen therapy and/or administer humidified oxygen therapy and/or administer humidified oxygen therapy and/or added while oxygen is being delived birector of nursing and/or designed responsible for compliance. Audits on oxygen therapy administrorders and resident tolerance will be wk for 2 weeks, weekly x 2 weeks to monthly to ensure compliance. Audit results will be reviewed by the | e e of dents were and eeded. De um e MD native are are are are red. E is ration egin 2x then | |
| | R28's nostrils twice | e daily for dryness. Staff tervention as completed, | | | Administrator and the Administrator take the audit results to QAPI for re | r will | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ' | TIPLE CONSTRUCTION NG | CON | (X3) DATE SURVEY COMPLETED | |
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| | PROVIDER OR SUPPLIER / HEALTH & REHABIL | LITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CO 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430 | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
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| F 689 | throughout November 11/24/21, in which F facility. During an interview consultant pharmack recommended using a petroleum-based potential problems of lubricant with liquid when there was an could react violently cause significant but but but but but but but but but bu | or, with the exception of R28 was noted to not be at the on 11/30/21, at 4:25 p.m. the sist (CP) stated he g a water-based lubricant over lubricant. The CP stated of using a petroleum-based oxygen could cause burning open flame. Further, oxygen with oily substances and urns. on 12/1/21, at 1:20 p.m. the DON) stated she was for petroleum jelly was to be for R28. The DON confirmed or petroleum jelly to R28's | F 6 | and recommendation. | | |
| F 693 SS=D | spark or flame. The contact R28's prima discontinuing the or Facility policy titled (undated), directed flammable items su and smoking article where oxygen was Tube Feeding Mgm CFR(s): 483.25(g)(4)-(5) E (Includes naso-gas both percutaneous percutaneous endo enteral fluids). Base | Oxygen Administration staff to remove all potentially such as lotions, oils, alcohol, as from the immediate areas to be administered. t/Restore Eating Skills 4)(5) Interal Nutrition tric and gastrostomy tubes, endoscopic gastrostomy and scopic jejunostomy, and | F 6 | 93 | | 1/10/22 |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | E CONSTRUCTION | | E SURVEY PLETED |
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| | | 245544 | B. WING | | | (12/0 | C 02/2021 |
| NAME OF | PROVIDER OR SUPPLIER | | ı | ST | FREET ADDRESS, CITY, STATE, ZIP CODE | | <i>5</i> <u> </u> |
| VIOTORY | / LIEALTIL O DELLADI | LITATION OFNITED | | 51 | 12 49TH AVENUE NORTH | | |
| VICTOR | / HEALTH & REHABI | LITATION CENTER | | M | INNEAPOLIS, MN 55430 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | FIX (EACH CORRECTIVE ACTION SHOULD BE | | | (X5) COMPLETION DATE |
| F 693 | eat enough alone of enteral methods up condition demonst clinically indicated resident; and §483.25(g)(5) A remeans receives the services to restore and to prevent contincluding but not limited in the properties of the services to restore and to prevent contincluding but not limited in the prevent continuity in the services and the prevent continuity in the services and to prevent continuities, and This REQUIREME by: Based on observatives, the facility was administered at (R28) who received findings include: R28's Admission FR28's diagnoses in arthritis (causes parthritis (causes parthritis) (causes parthritis) and services and services and services and services and services and services are services and ser | ent- sident who has been able to or with assistance is not fed by alless the resident's clinical rates that enteral feeding was and consented to by the sident who is fed by enteral e appropriate treatment and, if possible, oral eating skills aplications of enteral feeding mited to aspiration pneumonia, dehydration, metabolic nasal-pharyngeal ulcers. NT is not met as evidenced ation, interview, and document failed to ensure a tube feeding as ordered for 1 of 2 residents do a tube feeding. Second dated 12/2/21, indicated actually diabetes, rheumatoid ain, swelling, stiffness, and loss and a pressure ulcer. Simum Data Set (MDS) dated a R28 was cognitively intact. Indication R28 received a tube are area assessment (CAA) | F 6 | 593 | R 28 MD was notified on 12/1/202 enteral feeding was omitted. R 28 experience any ill effects from this feeding omission. R 28 oral and enfeeding order was reviewed along vare plan. Updates were made as needed. All other residents receiving enteral feeding orders and care plan reviewed and updated as needed. resident enteral feeding administration be followed per MD order. Licensed Nurses was in-serviced of enteral feeding policy and procedur focus on recording the date/time when the feeding was hung on the latt that the enteral feeding order was checked against the physician order Director of nursing and/or designed | did not enteral teral with the or was Future tion will on the re with the oel and er. | |
| | | ated R28 required tube er nutritional needs. | | | responsible for compliance. Audits on enteral feeding administration procedure will begin 2x wk for 2 we | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | COM | (X3) DATE SURVEY COMPLETED | |
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| | | 245544 | B. WING | ····· | | C 02/2021 | |
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| F 693 | at risk for impairer received a tube fere needs due to a his swallowing) and had the care plan including providing supplements, wat R28's Order Sumdirected staff to pure plastic tube place abdomen into the intestine) and Isos mL per hour for 12. The tube feeding and turned off at the Isosource formular remaining in the Isosource formular remaining in the Isosource formular and tubing lacked During an observer was at a 25-to-30 connected to the bottle of Isosource bottle. And isosource bottle of Isosource bottle of Isosource bottle. And in ot disconnected to the remaining and room isosource bottle. And isosource connected to the standard room isosource bottle. And isosource bottle. And isosource connected to the standard room isosource bottle. And isosource connected to the standard room isosource bottle. And isosource connected to the standard room isosource bottle. And isosource connected to the standard room isosource bottle. And isosource connected to the standard room isosource bottle. And isosource connected to the standard room isosource bottle. And isosource connected to the standard room isosource bottle. And isosource connected to the standard room isosource connected to the standard room isosource bottle. And isosource connected to the standard room isosource connected room isosourc | ated 7/13/21, indicated R28 was dinutrition and hydration. R28 eding to meet her nutritional story of dysphasia (difficulty istory of aspiration pneumonia. uded several interventions givitamin and mineral er flushes, and feedings. The rovide 100 milliliter (mL) water hours through a j-tube (soft, difficulty difficulty istory of aspiration of the midsection of the small source (nutrition formula) 100 2 hours per day, as tolerated. was to be started at 10:45 a.m. 10:45 p.m. The tubing connected to nula was hung feeding pump was shut off. The tubing connected to nula was hung over the pole dito R28. The Isosource formula | F6 | weekly x 2 weeks then mocompliance. Audit results will be review Administrator and the Admitake the audit results to Quand recommendation. | ved by the ninistrator will | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | TIPLE CONSTRUCTION ING | | | E SURVEY PLETED |
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| | PROVIDER OR SUPPLIER / HEALTH & REHABIL | LITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CO 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430 |)DE | 12/ | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD | BE | (X5) COMPLETION DATE |
| F 693 | confirmed the tubin formula had dried so A progress note datindicated R28's phymissed tube feeding given to restart the hour on/off cycle. During an observating R28 was laying in beconnected to the tule LPN-C confirmed so tube feeding during. During an observating R28 still was not concerved to the tule LPN-C confirmed so tube feeding during. During an interview medical doctor (MD and provided a vertoorder, to immediate and monitor for derhad been multiple of which orders were addirected. MD-B statifeeding could potent expected the facility. During an interview assistant director of tube feeding did no on 11/30/21. The Alimmediately start R reported the incider. During an interview and interview and interview and interview and interview. | tube feeding. LPN-C g connected to the Isosource ubstance on the end. ted 11/30/21, at 11:07 a.m. rsician was notified of the g (11/29/21) and an order was tube feeding and follow a 12 tion on 11/30/21, at 2:25 p.m. red and awake. R28 was not be feeding. At 2:28 p.m. red and complete R28's the shift as she was busy. tion on 11/30/21, at 4:00 p.m. rnnected to the tube feeding. on 11/30/21, at 9:30 a.m. ty)-B stated he assessed R28 real order, and later signed an ely resume R28's tube feeding rydration. MD-B stated there reccasions at the facility in red followed, or started, as red not starting R28's tube ritially cause harm and red follow orders as given. on 12/1/21, at 1:43 p.m. the follow orders as given. DON stated she told LPN-C to 28's tube feeding and | F 6 | 93 | | | |

| _ | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | TIPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED | |
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| F 693 F 697 SS=G | staff to follow order and nursing supervishould had restarted instructed to do so DON stated R28 without receiving not a progress note daindicated MD-B was feeding. Facility policy titled Precautions (undained responsible for preadministering etern trained, qualified, a responsibilities. Further date, time, and initioning and administration of the pain Management. | rs provided by the physician risor. The DON stated LPN-C and R28's tube feeding when by the ADON on 11/30/21. The ent more than 24 hours utrition. Ited 12/1/21, at 6:41 p.m. is notified R28 missed a tube Enteral Feedings Safety red) directed all staff paring, storing, and real nutrition formulas will be and competent of rther, staff were directed to all the label when formula was | F 6 | | 1/10/22 | |
| | provided to resider consistent with pro the comprehensive and the residents' this REQUIREME by: Based on observareview, the facility medication as orderesident (R28) reviactual harm for R2 signs of pain when pain medication was | anagement. Insure that pain management is ats who require such services, fessional standards of practice, a person-centered care plan, goals and preferences. In the property of the property | | R 28 MD was made aware that the medication was inadvertently crust administered to the resident. The response will be recorded in the reelectronic medical record. R 28 has new pain assessment completed, medication reviewed and care plant updated as needed. All existing residual records. | hed and MD esident ad a pain n | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
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| F 697 | R28's diagnoses in ulcer of sacral regic connects to the low absence of right and R28's quarterly Min 10/27/21, indicated and had scheduled pain medications. The limited R28's daily a pain at 8 out of 10 R28's Care Area As 5/13/21, indicated I rheumatoid arthritis of the spinal colum vascular disease (cand neuropathy (dacauses pain). The opioids (narcotic padirected to administ Pain impacted R28 she experienced padminister pain metreatment and antic relief. Additionally, immediately to comnon-verbal signs of was frequently 6 ou R28's care plan darreceived pain mediately to an endiately to comnon-verbal signs of was frequently 6 ou R28's care plan darreceived pain mediately to comnon-verbal signs of was frequently 6 ou R28's care plan darreceived pain mediately to comnon-verbal signs of was frequently 6 ou R28's care plan darreceived pain mediately to comnon-verbal signs of was frequently 6 ou R28's care plan darreceived pain mediately to comnon-verbal signs of was frequently 6 ou R28's care plan darreceived pain mediately to comnon-verbal signs of was frequently 6 ou R28's care plan darreceived pain mediately to comnon-verbal signs of was frequently 6 ou R28's care plan darreceived pain mediately to comnon-verbal signs of was frequently 6 ou R28's care plan darreceived pain mediately to componently 6 ou R28's care plan darreceived pain mediately to componently 6 ou R28's care plan darreceived pain mediately to componently 6 ou R28's care plan darreceived pain mediately 6 ou R28's care plan dar | ecord dated 12/2/21, indicated cluded diabetes, pressure on (area where the spine for half of the body), and d left leg above knee. Simum Data Set (MDS) dated R28 was cognitively intact pain medications, as needed and non-medication MDS further indicated pain activities and she rated her (0 to ten scale). Seessment (CAA) dated R28 had pain related to be concerned as the company of the nerves which CAA further indicated R28 took ain medication) and staff were the medications as ordered. The sability to sleep at night and the ain frequently. Staff were to dication 30 minutes prior to be spate R28's need for pain staff were to responding the repain. R28 reported her pain. | F 697 | who are receiving narcotic pain medications were reviewed and the plan was updated as needed. Furesidents will have medications deas ordered. Director of nursing and/or designer responsible for compliance. Nurses and TMA's will be in-service. Trushing Medication policy with foitem #2 that if a medication that she crushed, a physician must docreason and an order must be obtained along with medicating residents. Licensed nurses will be in-service. Pain Management Policy and prowith emphasis on identify cause (she and request pre-medication pain of the pain is adequately controlled. Consultant pharmacy will be contaperform medication competency as be scheduled as they are availabled Audits on medication administration procedure will begin 2x wk for 2 wheekly x 2 weeks then monthly to compliance. Audit results will be reviewed by the Administrator and the Administration and recommendation. | ture elivered ee is ced on ocus on houldn't ument ained d on the cedure elivered ensure eacted to and will ee. on reeks, ensure ene or will | |

| STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245544 | B. WING | | | C 12/02/2021 | |
| | PROVIDER OR SUPPLIER / HEALTH & REHABII | LITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP C 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430 | | 12/02/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE | |
| F 697 | analgesic medicatic R28's care plan ind related to rheumaton neuropathy and dire analgesia 30 minut and offer nonmedic as distraction, warn gentle massage. A Physician's Progrindicated R28 had a cervical stenosis st permanently connesacral pressure ulcidentified R28's chracervical myopathy (rheumatoid arthritis extremity contractured R28's Order Summ 8:57 a.m. indicated ordered a dysphasimechanical soft die may have medicatifor easy swallowing Review of R28's Not Administration Rectangle the following medication of Gabapentin Liquic milliliter (mL). Give times a day for neustarted on 11/15/21 - Morphine Sulfate pain medication). Of times a day for chrace Acetaminophen (Tanalage). | irected staff to administer ons, as ordered. Additionally, icated R28 had chronic pain oid arthritis, diabetic ected staff to administer es prior to treatments or cares sinal forms of pain relief such in packs, cold packs, and ress Note dated 11/8/21, diagnoses of chronic pain, atus post-fusion (surgery to ct two or more vertebrae) and er. The progress note also onic pain was related to (compression of spinal cord), a, sacral pressure ulcer, upper re and immobility. Paragraphy Report printed 12/2/21, at R28 had a tube feeding, was a (difficulty swallowing) at with nectar thick liquids. Staff ons crushed with applesauce of the cordered for pain: a 250 milligrams (mg) /5 300 mg (6 mL) by mouth three ropathic pain. The order was . Extended-Release (narcotic live 15 mg by mouth three | F6 | 97 | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| F 697 | mg. Give one table pain. Further, the M R28 was administer 11/5/21, 11/6/21, 11 11/29/21, and 11/30 not available. A Pain Management 11/29/21, indicated pain and had pain a her buttock, leg, and which was described R28 received morp Further, R28 should physical and occup morphine sulfate exto 15 mg three times continue administer 6 mL of times daily. During a continuou 11/29/21, from 8:30 noted to be lying flapillow to the right of closed, and she was called out to staff to moaning, "ouch." A for help and stated licensed practical in Throughout the obs R28's room, nor recalling out periodical reconstructions. | or pain. id; reduces inflammation) 5 via g-tube one time daily for MAR lacked documentation red Prednisone on 11/4/21, /7/21, 11/8/21, 11/11/21, 0/21, as the medication was at Progress Note dated R28 was frustrated with her all day. R28's reported pain in d had increased arm pain, ed as sharp, achy, and sore. hine and gabapentin for pain. d continue to work with ational therapy. R28's extended release was increased es a day. Staff was also to ring acetaminophen every six Further, staff were to gabapentin 250 mg/5mL three s observation conducted on 0 a.m. to 11:43 a.m. R28 was at on her back, in bed, with a fi her bed. R28's eyes were as noted to be moaning and on help. At 10:30 a.m., R28 was at 11:43 a.m., R28 called out she had pain. At 11:44 a.m., urse (LPN)-C was notified. Servation, no staff entered sponded to R28 who was ally. Three hours and 14 d. LPN-C stated they would | F 69 | 7 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245544 | B. WING | | | C 12/02/2021 | |
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| F 697 | stated she had a lo never be under conso uncomfortable was out of 10 and felt she was 3 out of 10 a good quality of life bad. During an observat LPN-C crushed morelease 15 mg table placed in a plastic rathe medications, LF asked R28 if she has "Yes, I hurt all over. R28's G-tube and of G-Tube to administ to LPN-C, "I hurt regrimacing and was pour multiple medication cup, and cup, and dumped in medication administ During observation her pain or offer no pain relief. During an interview LPN-C stated all of crushed because the stated all of R28's ray whether crushed feeding. LPN-C expendications to R28 was an order from the she was not aware | age 26 If on 11/29/21, at 9:02 a.m. R28 It of pain and it seemed to atrol. R28 verbalized she was when staff moved her or It reported her pain was 8 out would be able to manage if her It reported her pain was 8 out would be able to manage if her It reported her pain was so It repor | F 6 | 97 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | |
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| | | 245544 | B. WING | | 12 | C / 02/2021 | |
| | PROVIDER OR SUPPLIEF | | STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430 | | • | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | |
| F 697 | did not offer as ne other methods of comfortable. Subsequent review Medication Adminindicated licensed administered exte on 11/15/21, 11/16/11/24/21, 11/25/21/11/30/21. For each R28's pain was raa of to 10 scale). During an observed a bed bath by nurscomplained of painer right arm was facial grimacing where right arm was facial grimacing where we worse when such as incontiner confirmed R28 ye day and when here to buring an interview medical doctor (MR28's extended-recrushed or given when such as all that once and not proshould. MD-A statemuch morphine as all that once and not proshould. MD-A statemuch morphine as all that once and not proshould. MD-A statemuch morphine as all that once and not proshould. MD-A statemuch morphine as all that once and not proshould. MD-A statemuch morphine as all that once and not proshould. MD-A statemuch morphine as all that once and not proshould. MD-A statemuch morphine as all that once and not proshould. MD-A statemuch morphine as all that once and not proshould. MD-A statemuch morphine as all that once and not proshould. | ef. LPN-C also confirmed she eded acetaminophen to R28 or pain relief to keep R28 w of R28's November 2021 intration Record (MAR) practical nurse (LPN)-C ended-release morphine to R28 is 21, 11/17/21, 11/19/21, 11/26/21, 11/29/21, and ended from 3 to 5 out of 10 (using attion on 11/30/21, at 9:41 a.m. of lying in bed and was provided sing assistant (NA)-A. R28 in when repositioned and when moved. R28 also had noted hen she received cares. w on 11/30/21, at 9:50 a.m. and a lot of pain and R28's pain staff attempted to perform cares ance cares or bathing. NA-A led out in pain throughout the right arm was touched. w on 11/30/21, at 1:55 p.m. D)-A stated he was not aware blease morphine was being via a tube feeding. MD-A stated ld not crush extended-release e medication would release all rovide coverage for pain as it ed R28 could also receive too conce instead of receiving the over time. This could cause | F 69 | 7 | | | |

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| F 697 | concerns regarding stated they did not appropriate pain concerns. R28. During an interview consultant pharma extended-release recover the length of to not have comple pain. The CP state medication in the bear morphine was one was three hours. If was crushed it wouthree hours and no intended and cause management. During an observating R28 was provided pressure ulcers and pain when reposition noted to flinch and touched. R28 verbachest and arms. Radiffered pain medic. Subsequent review December 2021 Madministered as not 160mg/5mL (650 minimultation). Acetaminophen was stated to the stated and the subsequent review December 2021 Madministered as not 160mg/5mL (650 minimultation). Acetaminophen was stated to the stated and the subsequent review December 2021 Madministered as not 160mg/5mL (650 minimultation). | problems or relate to R28's poor pain control. MD-A feel the facility provided ontrol and management for on 11/30/21, at 4:25 p.m., the cist (CP) stated crushing morphine possibly could not time needed and caused R28 ste coverage for her chronic d the peak (highest level of a lood) for immediate release hour and extended release extended-release morphine ald peak between one and t last the full 12 hours as a inadequate pain sion on 12/1/21, at 12:00 p.m. wound care to her stage IV d moaned and complained of oned. R28 was tearful and was had facial grimacing when alized she had pain in her 28 was not observed to be ation prior to wound care. of R28's November 2021 and AR indicated R28 was seded Acetaminophen Solution and on 11/12/21, 11/14/21, 6/21. There was no indication as consistently used prior to or other times when R28 | F6 | 97 | | | |
| | During an interview | on 12/1/21, at 1:42 p.m. the | | | | | |

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| NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430 | | |
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| F 697 | aware R28's extended as indicated or a remedication at once expected staff to accordered and follow-impacted a resident During an interview MD-C stated R28 h care visits. MD-C stated repositioned every twheelchair, and have care. MD-C stated she had complained Facility policy titled (ADLs) undated, dirinterventions to minimicude appropriate Provision of Medica CFR(s): 483.40(d) §483.40(d) The facility facomprehensive associative discharge planning had ongoing allegative and position of Medically-related somaintain the highest and psychosocial was all psychosocial was a | DON) stated she was not ded-release morphine was, may not provide pain relief sident could receive too much. The DON stated she diminister medication as up with the physician if pain it's quality of life. on 12/1/21, at 12:25 p.m. ad a lot of pain during wound tated she had given direction R28's pain so she could be two hours, sit up in her are less pain during wound during her visit today with R28, dof pain. Activities of Daily Living rected to offer alternative himize functional decline and pain management. Ally Related Social Service dility must provide pocial services to attain or the practicable physical, mental rell-being of each resident. At is not met as evidenced ion, interview, and document | F 69 | | As of lave 00. R | |

| STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | COM | (X3) DATE SURVEY COMPLETED | |
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| _ | PROVIDER OR SUPPLIER / HEALTH & REHABII | LITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIF 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430 | | V =/=V= · | |
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| F 745 | Findings include: R500's quarterly Mi 11/12/21, identified impairment and wa activities of daily livincluded age-relate abuse. R500's care plan re R500 was, "At risk to] poor impulse codementia, level 1 salso included, "On touch[ing] another is south hall." On 9/20 care plan instructed female residents," 'alternative placeme making sexual gestredirect him back to enter a female reside immediately," [R500 besides South hall "[R500] will not enter from female reside inappropriate behavior Contraction outlined, "Boundari inappropriate behavior Contraction | inimum Data Set (MDS) dated R500 had a severe cognitive s independent with all ing (ADLs). R500's diagnoses d cognitive decline and alcohol evised on 9/23/21, identified of abusing others r/t [related ntrol, alcohol induced ex offender." The care plan 8/27/21 resident accused of resident inappropriately near 3/21, "accused of kissing." The d staff to, "Redirect away from 'Assist in looking [for] ent," If staff hear [R500] tures tell him to stop and o his room," "If staff see [R500] dent's room, remove resident of is not to be in any other hall without supervision," and er north hall, will stay away nt" related to allegations of vior. It signed by R500 on 11/13/20, es related to allegations of vior: hing any female resident, even g from you. ring female resident's rooms. s areas refrain from making | F 7- | facility. All other residents discharge will be reviewed planning will be documen residents will be assessed admission for discharge prodischarge potential will be reviewed per policy. Social Services designee in-serviced on the transfe policy and procedure with notification 30 days in advimpending discharge and all aspects addressed for resident. Social Services and/or de responsible for compliance Audits on resident dischar procedure will begin 2x wweekly x 2 weeks then mocompliance. Audit results will be review Administrator and the Adritake the audit results to Cand recommendation. | d and discharge ted. Future d upon plans and e care plan and will be er, discharge a emphasis on vance for assistance with the needs of the esignee will be ee. rge planning ek for 2 weeks, onthly to ensure wed by the ministrator will | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTI NG | | | E SURVEY PLETED |
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| | | 245544 | B. WING | | | | C 02/2021 |
| | PROVIDER OR SUPPLIER / HEALTH & REHABII | LITATION CENTER | | 512 49TH | ODRESS, CITY, STATE, ZIP CODE AVENUE NORTH POLIS, MN 55430 | 12/ | <i>52/202</i> 1 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULING OSS-REFERENCED TO THE APPROF DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 745 | with males." A progress note daincluded, "Spoke wreviewed transition expressed understabest interest." A Mental Health Prog/24/21, included, "[R500] kiss a femal previously shown in she is not interested find an all-male plaambivalent about thon the location." During an interview R501 stated that Riphysical with her arto do that." R501 st boobs. I don't like the Additionally, R500 sand she did not wadon't feel good about the same she did not wadon't feel good about the same she did not wadon't feel good about the same she did not wadon't feel good about the same she did not wadon't feel good about the same she did not wadon't feel good about the same she did not wadon't feel good about the same she did not wadon't feel good about the same she did not wadon't feel good about the same she did not wadon't feel good about the same she did not wadon't feel good about the same she did not wadon't feel good about the same she did not wadon't feel good about the same she was a level 1 sex on "couple" of reports | ted 9/23/21, at 1:47 p.m. ith resident and daughter, to another facility. Daughter anding and knowing it ws in his ovider Progress Note dated A resident reported seeing the resident who he has atterest in and who has stated d." "Staff continue to work to cement for [R500]. [R500] is his, but agreeable depending on 11/29/21, at 10:04 a.m. 500 wanted to be more and, "I told him, no. I don't want atted R500 liked to "touch my mat. I tell him, don't do that." I stated R501 liked to kiss her and to kiss him. R500 stated, "I ut it." | F 7 | 45 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION G | COM | E SURVEY IPLETED | |
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| | | 245544 | B. WING _ | | | C 02/2021 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430 | | 12/02/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE | |
| F 745 | during his stay at tallegations, R500 different hallway the ducated R500 and other. SW-A stated placement in an all unsuccessful. This placement at one facility approximate facility was unable status as a sex off additional inquiries placement. SW-A care conference son R500's daughter to considering transite facility or group hor director of rehability "be reasonable" to an alternative leve or a group home of independence with During an interview of a group home of independence with During an interview of the administrator at (ADON) the adminimplemented intervalternative placem facility. The ADON team had agreed to ongoing risk of ina facility's female resthought referrals to to multiple all-male declined at each fasex offender. The | he nursing home. Due to the was moved to a room in a nan R501 and staff were d R501 were not to touch each d she attempted to find R500 I-male facility, but was included inquiring about alternative skilled nursing ely two months ago, but the to accept R500 due to his ender. SW-A confirmed no were made for alternative stated R500 was "due for a con" and she could talk to be see if they were open to coning to an assisted living me. In on 11/30/21, at 4:07 p.m. the tation services stated it would be consider R500 for transfer to I of care such as assisted living considering R500's | F 74 | 5 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | E CONSTRUCTION | COMI | E SURVEY PLETED |
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| | PROVIDER OR SUPPLIER 7 HEALTH & REHABIL | ITATION CENTER | | 5 | TREET ADDRESS, CITY, STATE, ZIP CODE 12 49TH AVENUE NORTH IINNEAPOLIS, MN 55430 | | |
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| F 745 | or group home. The was unsuccessful wintervention he wou shared with the intervention he wous shared with the intervention he wous shared with the intervention. The facility Transfer dated 2001, include permitted to remain transferred or disch of individuals in the clinical or behavioral Free of Medication CFR(s): 483.45(f) (1) §483.45(f) Medication The facility must en service with the facility facility facility facility facility facility facility facility medication during the facility medication and 30% (percent). Findings include: R28's Admission ReR28's diagnoses includer of sacral region in the service of the service o | d transfer to an assisted living administrator stated if SW-A with implementing a behavior ld expect the information to be rdisciplinary team for and Discharges Policy d, "Each resident will be in the facility, and not be arged unless: C. the safety facility is engaged due to the all status of the resident." Error Rts 5 Pront or More) on Errors. | F 7 | | R 28 MD was notified that medicativere not administered as ordered of survey observation. The MD's responsible be recorded in the resident medication adverse reaction to this incorrect procedure. All other residents recemedications from the staff nurse we reviewed and no adverse effects we noted. Future residents will have the medication administered per MD or and nursing standard practice. Nurses and TMA staff were in-servithe medication administration policy enteral administration policy and | ions during onse dical y iving ere ere eir der | 1/10/22 |
| | | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245544 | B. WING | | 12/0 | C 02/2021 | |
| NAME OF I | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP | • | | |
| VICTORY | / HEALTH & REHABI | LITATION CENTER | | 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430 | | | |
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| F 759 | A Physicians Order may have their mer with applesauce for Review of R28's Not Administration Recovered to administer mouth: - Cefuroxime Axetil mouth two times a - Doxycycline 100 milligrams by mout joint infection. - Morphine sulfate extended-release to mouth three times - Famotidine 20 mg 20 mg twice daily. - Gabapentin 6 mL milliliters [mL]) by meuropathic pain. The November 202 following medication g-tube (tube feeding - Prednisone (sterestablet daily via g-tule). - Amlodipine 5 mg daily for high blood - Duloxetine 20 mg every Tuesday for experience and provided in the proposition of the provided in the proposition of the p | r dated 7/26/21, indicated R28 dication crushed and given r easy swallowing. ovember 2021 Medication ord (MAR), indicated staff the following medications by day for infection. milligram tablet. Give 100 th every 12 hours for bone and (pain medication) ablet 15 mg. Give one tablet by daily for chronic pain. If the total treats heartburn is grablet (treats heartburn). Give 250mg/5mL. Give 300 mg (6 mouth two times daily for 21 MAR further indicated the ons were to be administered via 190; and 5 mg tablet. Give one be for chronic pain. Tablet. Give 1 tablet via g-tube pressure. It tablet. Give 1 tablet via g-tube depression. The content of the | F 7 | procedure with emphasis of per physician order and meneed crushing must have a not to administer medication the tube and administering medication separately. Director of Nursing and/or be responsible for complian Audits on medication admin procedure will begin 2x wk weekly x 2 weeks then more compliance. Audit results will be reviewed Administrator and the Admit take the audit results to QA and recommendation. | edications that a specific order, ons directly into each designee will nce. nistration for 2 weeks, nthly to ensure ed by the inistrator will | | |

| | EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING | | CON | X3) DATE SURVEY COMPLETED | | | |
|--------------------------|---|---|---------------------|---|-------------|----------------------------|--|
| | | 245544 | B. WING _ | | | C / 02/2021 | |
| | PROVIDER OR SUPPLIER | LITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP C 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) COMPLETION DATE | |
| F 759 | - Famotidine 20 mg - Metoprolol Tartra - Gabapentin 6 mL - Prednisone 5 mg medication was un On 11/30/21, at 9:1 to crush the above them in medication poured Gabapentin medication cup wit cup (with measurin was unable to be of Gabapentin was in then gathered sup LPN-C connected g-tube and pulled to G-tube, using a sy mixed four medica administered in G- next administered medication and flu administered the la mixed together wit and flushed with w During an interview LPN-C stated all m for R28 because th stated she was late administration and tablets were not av confirmed she pour | mg extended-release 15 mg g te 50 mg 250mg/5mL give 300 mg was not prepared as the available. 3 a.m. LPN-C was observed noted medications and placed cups. Additionally, LPN-C 250mg/5mL into a plastic measurement lines on the g lines labeled 2.5, 5, 7.5). It letermined it 6 mL of the medication cup. LPN-C colies and went into R28's room. connected the syringe to R28's back. LPN-C then flushed the ringe, with water. LPN-C then tions together with water and tube with water flush. LPN-C the liquid gabapentin shed with water. LPN-C then ast three crushed medication meast three crushed medication meast water, gave in R28's G-tube, ater. y on 11/30/21, at 9:13 a.m. medications could be crushed mere was an order. LPN-C also | F 75 | 9 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | | 245544 | B. WING | | 12 | C / 02/2021 |
| | PROVIDER OR SUPPLIER | LITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CO 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430 | | /OZ/ZGZ 1 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 759 | was not available. I given R28 too muc accurately. Further to crush medication was to place the m give by mouth. LPN should be followed asked if there were all oral medications g-tube. During an interview medical doctor (ME give medications a absorption and relice to use a sygabapentin to ensure the medication order. The practice to use a sygabapentin to ensure the medication orders were ordered by m given by mouth. If a condition, the physician. During an interview director of nursing staff passing medication, and the medication, and the | nad used a syringe, but one LPN-C stated she could had h gabapentin it not measured, she knew R28 had an order ns, but was not aware to order edication in applesauce and N-C stated the physicians order and the physician should be equestions. LPN-C confirmed aware cocktailed and given via on 11/30/21, at 1:55 p.m. D)-A stated he expected staff to sordered to ensure proper | | 9 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245544 | B. WING | | | C (02 / 2021 | |
| | PROVIDER OR SUPPLIER | LITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430 | | JE / ZJ E | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | |
| F 759 | dose, right medicat before medications individual had ques should ask prior to stated medications via a tube feeding, considered a medic should not estimate DON stated LPN-C medication errors a education and gues error. Facility policy titled Medications (undat administering medications | ion, right route, and right time were administered. If an tions about an order, they administration. The DON which were crushed and given rather than by mouth, were cation error. Further, LPN-C a dose of gabapentin. The would need to write up and she would provide staff assed all staff made the same | F 7 | 59 | | | |



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 19, 2021

Administrator Victory Health & Rehabilitation Center 512 49th Avenue North Minneapolis, MN 55430

Re: State Nursing Home Licensing Orders

Event ID: CRPT11

Dear Administrator:

The above facility was surveyed on November 29, 2021 through December 2, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

Victory Health & Rehabilitation Center December 19, 2021 Page 2

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jamie Perell, Unit Supervisor Metro B District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: jamie.perell@state.mn.us

Office: (651) 245-8094

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kamala Fiske Downing

Victory Health & Rehabilitation Center December 19, 2021 Page 3

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

(X6) DATE

Minnesota Department of Health

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 00166 | B. WING | | C 12/02/2021 | |
| NAME OF I | PROVIDER OR SUPPLIER | | L DRESS, CITY, S | STATE, ZIP CODE | 12/02/2021 | |
| VICTORY | / HEALTH & REHABIL | ITATION CENTEL | AVENUE NO | | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID ID | PROVIDER'S PLAN OF CORRECTION | | |
| PREFIX TAG | | ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | | ΓE |
| 2 000 | Initial Comments | | 2 000 | | | |
| | *****ATTE | NTION***** | | | | |
| | NH LICENSING | CORRECTION ORDER | | | | |
| | 144A.10, this correct pursuant to a surve | Minnesota Statute, section order has been issued y. If, upon reinspection, it is | | | | |
| | herein are not corre not corrected shall | iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of | | | | |
| | the Minnesota Depa | | | | | |
| | corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess | nether a violation has been compliance with all rule provided at the tag alle number indicated below. It is several items, failure to the items will be considered Lack of compliance upon my item of multi-part rule will ment of a fine even if the item uring the initial inspection was | | | | |
| | that may result from orders provided tha the Department witl | hearing on any assessments non-compliance with these tawritten request is made to nin 15 days of receipt of a nt for non-compliance. | | | | |
| | was conducted at y the Minnesota Depa facility was found N State Licensure. Pla plan of correction ye | TS: gh 12/2/21, a complaint survey our facility by surveyors from artment of Health (MDH). Your OT in compliance with the MN ease indicate in your electronic ou have reviewed these orders e when they will be completed. | | | | |

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 12/27/21

STATE FORM 6899 CRPT11 If continuation sheet 1 of 35

TITLE

| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| | | 00166 | b. Willa | | 12/0 | 2/2021 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| VICTORY | / HEALTH & REHABII | ITATION CENTEL | AVENUE NO OLIS, MN 5 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES OF THE | D BE | (X5) COMPLETE DATE |
| 2 000 | Continued From pa | ge 1 | 2 000 | | | |
| | SUBSTANTIATED: H5544247C (MN00 cited at 0920. H5544239C (MN00 deficiencies cited a deficiencies were in the state of the s | 2065151), with a deficiency 2066995), MN00067027), with 30930 and 1545. Additional 30978872), with a deficiency 3071021), with a deficiency 3068284), with a deficiency 3078922), with a deficiency | | | | |
| | were cited due to a facility prior to surve (MN00058115), H5 H5544122C (MN00 (MN00060483), H5 | ctions implemented by the | | | | |
| | UNSUBSTANTIATE deficiencies were c | plaints were found to be ED, however, related ited: H5544242C a deficiency cited at 1475. | | | | |
| | UNSUBSTANTIATE H5544256C (MN00 (MN00057021), H5 H5544272C (MN00 (MN00058601), H5 H5544266C (MN00 | blaints were found to be ED: 055236), H5544236C 544273C (MN00057643), 057811), H5544270C 544268C (MN00060411), 0060990), H5544265C 544269C (MN00058685), | | | | |

Minnesota Department of Health

STATE FORM 6899 CRPT11 If continuation sheet 2 of 35

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | D | (X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING: | | | |
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| | | 00166 | B. WING _ | | | C 02/2021 |
| | PROVIDER OR SUPPLIER Y HEALTH & REHABII | ITATION CENTER 51 | REET ADDRESS, CIT 2 49TH AVENUE NNEAPOLIS, MN | NORTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATION | | PROVIDER'S PLAN C (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIEN | CTION SHOULD BE O THE APPROPRIATE | (X5) COMPLETE DATE |
| 2 000 | H5544249C (MN00 (MN00062019), H5 H5544245C (MN00 (MN00063846), H5 H5544255C (MN00 (MN00066083), H5 H5525275C (MN00 (MN00071065), H5 H5544263C (MN00 (MN00075552), H5 H5544261C (MN00 (MN00077317), H5 H5544240C (MN00 (MN00077826), H5 H5544247C (MN00 (MN00077826), H5 H5544277C (MN00 Minnesota Department of the State Licensing Federal software. The state states of the State of the minnesota Department of the findings which a statute after the states of the correction order the findings which a statute after the states of the State of the | 1061566), H5544251C 1544257C (MN00063321 1063651), H5544246C 1544243C (MN00064999 1066066), H5544254C 1544244C (MN00067088 1069148), H5544250C 1544254C (MN00071120 1071185), H5544238C 1544235C (MN00076082 1077139, MN00076989). 1077301), H5544260C 1544241C (MN00077689 1077755), H5544274C 1544258C (MN00077787 1078748). Then of Health is documed and the state of the st | enting for refix nce is encies" on of des te tt met ndings id onic with ulatio sing | | | |

Minnesota Department of Health

STATE FORM 6899 CRPT11 If continuation sheet 3 of 35

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| 7.1.12 1 2 11 1 | 0. 0020 | | A. BUILDING: | | | |
| | | 00166 | B. WING | | 12/0 |) 2/2021 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| VICTOR | Y HEALTH & REHABII | IIAIION CENTEL | AVENUE NO OLIS, MN 5 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETE DATE |
| 2 000 2 265 | you electronically. is necessary for State enter the word "CO available for text. Y electronic State lice heading completion be corrected prior to the Minnesota Depis enrolled in ePOO not required at the state form. PLEASE DISREGATE FOURTH COLUMN "PROVIDER'S PLATE APPLIES TO FEDE THIS WILL APPEATH WILL APPEATH WILL APPEATH APPLIES TO FEDE THIS WILL APPLIES TO FED THIS WILL APPLI | Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please RRECTED" in the box ou must then indicate in the ensure process, under the date, the date your orders will o electronically submitting to artment of Health. The facility and therefore a signature is bottom of the first page of ARD THE HEADING OF THE WHICH STATES, IN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE. 5 Notification of Chg in atus | 2 000 | | | 1/10/22 |
| | physicians, physicial practitioners, and if legal representative member of a reside accident, or death. nursing services, a attending physician development of the have criteria which appropriate notifical. | an assistants, and nurse known, notify the resident's or an interested family ent's acute illness, serious. At a minimum, the director of and the medical director or an must be involved in the se policies. The policies must address at least the tion times for: involving the resident which I has the potential for requiring | | | | |

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| STATEMEN | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|---|---|---------------------|---|-------------------|--------------------------|
| | | | | | C | |
| | | 00166 | B. WING | · | 12/0 | 2/2021 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| VICTORY | / HEALTH & REHABII | LITATION CENTEL | OLIS, MN 5 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 265 | Continued From pa | age 4 | 2 265 | | | |
| | physical, mental, o example, a deterior psychosocial status conditions or clinica C. a need to al example, a need to | ter treatment significantly, for discontinue an existing form adverse consequences, or to | | | | |
| | D. a decision tresident from the n | to transfer or discharge the ursing home; or | | | | |
| | E. expected an | nd unexpected resident deaths. | | | | |
| | This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician a resident was transferred to the hospital 1 of 4 residents (R29) reviewed for change of condition. | | | Corrected | | |
| | Findings include: | | | | | |
| | (MDS) dated 9/23/2 cognitively intact ar | nange Minimum Data Set 21, indicated R29 was nd had diagnoses which potension (low blood iety disorder. | | | | |
| | following: - 11/22/21, at 11:16 hospitalized 11/26/21, at 9:64 a hospital on observa complaints of vision | ogress notes revealed the p.m. indicated R29 was a.m. indicated R29 was at the ation status. R29 had n changes, was ruled out for a ile infection (bacteria which | | | | |

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STATE FORM 6899 CRPT11 If continuation sheet 5 of 35

| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM | | ENT OF DEFICIENCIES N OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--|---------|--|---|------------------------------|---|-------------------|--------------------------|
| VICTORY HEALTH & REHABILITATION CENTEI (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 265 Continued From page 5 causes severe diarrhea and inflammation of the colon) and had no new diagnoses. Review of R29's medical record lacked indication the physician was notified R29 was transferred to the hospital. During an interview on 12/1/21, at 3:18 p.m. | | | 00166 | B. WING | | | |
| (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 265 Continued From page 5 causes severe diarrhea and inflammation of the colon) and had no new diagnoses. Review of R29's medical record lacked indication the physician was notified R29 was transferred to the hospital. During an interview on 12/1/21, at 3:18 p.m. | NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 265 Continued From page 5 causes severe diarrhea and inflammation of the colon) and had no new diagnoses. Review of R29's medical record lacked indication the physician was notified R29 was transferred to the hospital. During an interview on 12/1/21, at 3:18 p.m. | VICTOR | ≀Y HEALTH & REHABII | ITATION CENTEL | | | | |
| causes severe diarrhea and inflammation of the colon) and had no new diagnoses. Review of R29's medical record lacked indication the physician was notified R29 was transferred to the hospital. During an interview on 12/1/21, at 3:18 p.m. | PREFIX | (EACH DEFICIENCY | / MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO | LD BE | (X5) COMPLETE DATE |
| to the emergency department on 11/22/21, and was placed on observation status at the hospital with a chief complaint of vertigo and failure to thrive. During an interview on 11/30/21, at 1:35 p.m. LPN-B stated R29 refused to take any medications on 11/22/21, and had notified the provider. R29 was not aware of any other concerns regarding R29 during their shift and verbalized they were not aware R29 was transferred to the hospital. During an interview on 11/30/21, at 2:50 p.m. licensed practical nurse (LPN)-A stated he observed R29 near the facility entrance on 11/30/21, at approximately 3:00 p.m. calling 911 when arriving for his shift. He was notified R29 had already left for the hospital when he started his shift, however, did not receive any detail regarding why R29 went to the hospital. During an interview on 12/1/21, at 10:59 a.m. physician assistant (PA)-A stated there were no call notes dictated on 11/22/12, indicating R29 was at the hospital, however there was a note LPN-B called to request R29 be rounded on as the resident, did not seem like themselves. PA-A stated they learned of R29's hospitalization during | 2 265 | causes severe diarrecolon) and had no recolon) and had no recolon and had already left for his shift, however, cores regarding why R29 During an interview licensed practical nobserved R29 near 11/30/21, at approximate when arriving for his had already left for his shift, however, coregarding why R29 During an interview physician assistant call notes dictated of was at the hospital, LPN-B called to recolon and had no recolon a | rhea and inflammation of the new diagnoses. edical record lacked indication notified R29 was transferred to a on 12/1/21, at 3:18 p.m. A stated R29 was transferred lepartment on 11/22/21, and lervation status at the hospital int of vertigo and failure to a on 11/30/21, at 1:35 p.m. refused to take any 22/21, and had notified the not aware of any other R29 during their shift and re not aware R29 was ospital. From 11/30/21, at 2:50 p.m. urse (LPN)-A stated her the facility entrance on imately 3:00 p.m. calling 911 shift. He was notified R29 the hospital when he started did not receive any detail went to the hospital. From 12/1/21, at 10:59 a.m. (PA)-A stated there were no on 11/22/21, indicating R29 however there was a note quest R29 be rounded on as t seem like themselves. PA-A | | DEFICIENCY) | | |

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|--|---------------------|---|-------------------|--------------------------|
| | | | A. BUILDING. | | | |
| | | 00166 | B. WING | | | , 2/2021 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| VICTORY | HEALTH & REHABII | I ITATION CENTEL | AVENUE NO | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | .D BE | (X5) COMPLETE DATE |
| 2 265 | Continued From pa | ige 6 | 2 265 | | | |
| | when a resident wa and further verbaliz not an isolated incident | he provider, or call center, as transferred to the hospital and the lack of notification was dent for the facility. PA-A know what lead to R29's | | | | |
| | director of nursing (why R29 was hospi up to R29 going to R28's medical reco R29 was hospitalize notification. The DC | on 12/2/21, at 10:10 a.m. the (DON) stated she did not know italized or the events leading the hospital. The DON verified and lacked indication of why ed or subsequent provider DN stated she expected staff and document the notification. | | | | |
| | Condition or Status facility would promp | A Change in a Resident's (undated), indicated the otly notify the physician of a change or change in | | | | |
| | director of nursing (review and revise p providers are notified change of condition The DON, or design on the policies and | THOD OF CORRECTION: The (DON), or designee, could colicies to ensure medical ed when a resident has a n and/or sent to the hospital nee, could then educate staff procedures and developing and monitoring consistent | | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: Twenty-one | | | | |
| 2 830 | MN Rule 4658.0520 Proper Nursing Car | 0 Subp. 1 Adequate and re; General | 2 830 | | | 1/10/22 |
| | Subpart 1. Care in | general. A resident must | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION (X3) DATE : COMPI | | SURVEY LETED | | |
|--|---|--|--------------------------|--|------|--------------------------|
| | | 00166 | B. WING | | 12/0 |) 2/2021 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| VICTORY | / HEALTH & REHABIL | ITATION CENTEL | AVENUE NO POLIS, MN 5 | • • • • • | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 830 | receive nursing care custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the | e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a he attending physician that the in in bed or the resident | 2 830 | | | |
| | This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure oxygen was administered in accordance with acceptable standards of practice to reduce the likelihood of potential accident hazards for 1 of 1 resident (R28) who was administered oxygen therapy. | | | Corrected | | |
| | R28's diagnoses inc (inflammation of lur respiratory failure. R28's Order Summ directed staff to app into both of R28's n R28's care plan dat received oxygen the exchange and direct at I liter per minute | ary Report dated 11/30/21, oly a small amount of Vaseline ostrils twice daily for dryness. ed 9/17/21, indicated R28 erapy related to ineffective gas eted staff to administer oxygen (LPM). | | | | |
| | Review of R28's Tre | eatment Administration Record | | | | |

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| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLI A. BUILDING: | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|---|--|---|--|-------------------|--------------------------|
| | | 00166 | B. WING | | 12/0 |) 2/2021 |
| | PROVIDER OR SUPPLIER Y HEALTH & REHABIL | ITATION CENTER 512 49TH | DDRESS, CITY, S I AVENUE NO POLIS, MN 5 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 830 | (TAR) dated 11/30/2 apply a small amou R28's nostrils twice documented the int throughout Novemb 11/24/21, in which I facility. During an interview consultant pharmac recommended usin a petroleum-based potential problems lubricant with liquid when there was an could react violently cause significant but During an interview director of nursing (surprised an order functions and could capark or flame. The contact R28's primal discontinuing the or Facility policy titled (undated), directed flammable items suand smoking article where oxygen was SUGGESTED MET director of nursing (review and revise pregarding safe admirelates to using nor surplementations). | 21, indicated staff were to ant of Vaseline into both of daily for dryness. Staff ervention as completed, per, with the exception of R28 was noted to not be at the on 11/30/21, at 4:25 p.m. the cist (CP) stated he g a water-based lubricant over lubricant. The CP stated of using a petroleum-based oxygen could cause burning open flame. Further, oxygen with oily substances and urns. If on 12/1/21, at 1:20 p.m. the (DON) stated she was for petroleum jelly was to be for R28. The DON confirmed or petroleum jelly to R28's cause burning if ignited by a poon stated she would ary physician regarding of certain constant of the constant of t | | | | |

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STATE FORM 6899 CRPT11 If continuation sheet 9 of 35

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMP | | | SURVEY LETED | |
|--|--|---|---------------------|--|-----------------|--------------------------|
| | | 00166 | B. WING | | 12/0 |) 2/2021 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, | STATE, ZIP CODE | | |
| VICTORY | / HEALTH & REHABIL | ITATION CENTEL | AVENUE NO | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 830 | could then educate monitoring system tappropriate care. | | 2 830 | | | |
| 2 900 | Subp. 3. Pressure comprehensive res of nursing services development of a nursing services development of an approvides that: A. a resident who without pressure sores unlessure sores un service sores un s | Sores. Based on the ident assessment, the director must coordinate the ursing care plan which o enters the nursing home pres does not develop east the individual's clinical ates, and a physician they were unavoidable; and they were unavoidable; and they has pressure sores of treatment and services to event infection, and prevent reloping. | 2 900 | | | 1/10/22 |
| | by: Based on observati review, the facility for reassess and imple by the physician to the risk of complica ulcer for 1 of 3 resigneessure ulcers. The | ent is not met as evidenced on, interview, and document ailed to comprehensively ment interventions as ordered promote healing and reduce tions of an existing pressure dents (R28) reviewed for e resulted in actual harm for sening stage IV pressure | | Corrected | | |

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| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| | | | 71. 501251110. | | | |
| | | 00166 | B. WING | | 12/0 | 2/2021 |
| NAME OF | PROVIDER OR SUPPLIER | | , , | STATE, ZIP CODE | | |
| VICTOR | Y HEALTH & REHABI | I IIAIION CENTEL | AVENUE NO OLIS, MN 5 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE |
| 2 900 | Continued From pa | age 10 | 2 900 | | | |
| | Findings include: | | | | | |
| | Pressure Ulcer Det | finition: | | | | |
| | muscle. Slough or hard or soft in textutan in color, and matissue is usually firmand wound and oftwound), may be prundermining (outwand tunneling (passurface of the skin) | sposed bone, tendon, or eschar (Dead tissue that is ure, usually black, brown, or ay appear scab-like. Eschar mly adherent to the base of en the sides/edges of the esent. It often includes ardly visible wound margins) sageways underneath the). | | | | |
| | R28's diagnoses in ulcer of sacral region connects to the low | ocluded diabetes, pressure on (area where the spine wer half of the body), and and left leg above knee. | | | | |
| | 10/27/21, indicated and had no docum was totally dependent mobility, transfers, impairment to both and was always ind three documented were present upon | nimum Data Set (MDS) dated I R28 was cognitively intact ented rejection of care. R28 ent of two staff with bed and toilet use. R28 had an upper and lower extremities continent of bowel. R28 had stage IV pressure ulcers which admission. Several treatments ncluded pressure reducing d bed. | | | | |
| | indicated R28 was bed mobility, dress hygiene. The CAA | ssessment (CAA) dated 5/7/21, totally dependent of staff for ing, toilet use, and personal further indicated R28 required staff, with the use of hoyer lift | | | | |

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STATE FORM 6899 CRPT11 If continuation sheet 11 of 35

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|--|--------------------------|--|-------------------|--------------------------|
| | | | A. BUILDING: | | | , |
| | | 00166 | B. WING | | |)2/2021 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, S | STATE, ZIP CODE | | |
| VICTORY | / HEALTH & REHABI | LITATION CENTEL | AVENUE NO POLIS, MN 5 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 900 | to transfer Further, assistance of two s bed every two hour R28's care plan day stage IV pressure to ischium. The care is the potential to deverelated to incontine weakness. R28's conterventions include assessments and include assisting R wheelchair with a properties of the potential to deverelated to incontine weakness. R28's conterventions include assessments and include assisting R wheelchair with a properties of the protocol, and "may day and an addition break in the morning was to be reposition weekly skin checks morning. R28's worning. R28's worning | R28 required extensive staff to turn and reposition in a sand as necessary. Ited 9/19/21 indicated R28 had alcers on her sacrum right k part of the hip bone), and left plan further identified R28 had elop additional pressure ulcers ance, immobility, and are plan included several ding to conduct weekly skin provide wound care per orders. Its revised on 12/2/21, to 28 to sit up in tilt-in-space pressure reducing cushion for as not to exceed two hours of essure. In any Report dated 12/2/21, to 28 to offload R28, per facility be up in chair two hours per nal one hour after a two-hour and and afternoon. Further, R28 ned every two hours and have a completed every Tuesday and care orders included: and sacrum wound care: es of silver alginate (product ound healing) were removed d. Saturate 4 x 4 gauze with anser). The saturated gauze peed in R28's wound beds and and allow to sit for five gauze) and place silver sam boarder dressing in the | | | | |
| | | team (IDT) progress note :17 p.m. indicated R28 was | | | | |

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| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, 2IP CODE 12/02/2021 STREET ADDRESS. CITY, STATE, 2IP CODE 12/02/2021 STREET ADDRESS. CITY, STATE, 2IP CODE 12/02/2021 SUMMARY STATEBERT OF PERCENDERS IN STATE PROVIDERS PLAN OF CORRECTION SOUNDERS PLAN OF CORRECT | | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--|-----------|--|--|----------------|---|-------------------|-----------------|
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE ST2 49TH AVENUE NORTH MINNEAPOLIS, MN 55430 SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED FINAL PROVIDER STAN OF CORRECTION EACH DEFICIENCY MUST BE PROVIDERS PLAN OF CORRECTION EACH DEFICIENCY TAG CROSS REFERENCE TO THE APPROPRIATE 2 900 Continued From page 12 hospitalized from 101/121, to 10/20/21 due to severe sepsis secondary to a decubitus sacral wound abscess (collection of puss related to infection) and osteomyellitis. Additionally, R28 was under observation in the hospital on 11/24/21, related to chest pain. R28's Wound Physician Progress Note written by medical doctor (MD)-C dated 11/18/21, revealed the following: - R28's Wound Physician Progress Note written by medical doctor (MD)-C dated 11/18/21, revealed the following: - R28's stage IV sacral pressure wound measured 3.5 centimeters (cm), x 3.0 cm, x 2.0 cm, with undermining of 5.0 cm, at the three o'clock position. The wound had 80 percent granulation (new issue), 20 percent muscle and fascia (thin casing of connective tissue which holds muscle in-place), and moderate serous exudate (clear, thin, and watery fluid), R28's stage IV pressure wound to her right ischium measured 1.0 cm, x 1.0 cm, x 1.5 cm with abnormal granulation present. Recommendations included offloading the wound and repositioning per facility protocol. R28 may be up for two hours in their chair and one hour after a two-hour break. Review of R28's November 2021 Task Record, revealed no transferring/bed mobility was not documented for 2 of 3 opportunities. There were | | | | A. BOILDING. | | | |
| VICTORY HEALTH & REHABILITATION CENTE S12 49TH AVENUE NORTH MINNEAPOLIS, MN 55430 PREFIX SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH LOPE/CENCY MUST BE PRECEDED BY FULL FARE | | | 00166 | B. WING | | | |
| CALIFICATION CENTED MINNEAPOLIS, MN 55430 CALIFORNIA SUMMARY STATEMENT OF DEFICIENCIES MINNEAPOLIS, MN 55430 CALIFORNIA REGULATIONY OR LSC IDENTIFYING INFORMATION) PROVIDENTS PLAN OF CORRECTION CONSTRUCTION SHOULD BE (PACH DEFICIENCY MUST BE PRECEDED BY PLUI.) PROVIDENTS PLAN OF CORRECTION CONSTRUCTION CONTROL OF CROSS REFERENCE PROVIDENCY CALIFORNIA PROVIDENCE PROVIDENCE PR | NAME OF I | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, S | STATE, ZIP CODE | | |
| PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 900 Continued From page 12 hospitalized from 10/1/21, to 10/20/21 due to severe sepsis secondary to a decubitus sacral wound abscess (collection of puss related to infection) and osteomyelitis. Additionally, R28 was under observation in the hospital on 11/24/21, related to chest pain. R28's Wound Physician Progress Note written by medical doctor (MD)-C dated 11/18/21, revealed the following: - R28's stage IV sacral pressure wound measured 3.5 centimeters (cm.) x 3.0 cm. x 2.0 cm. with undermining of 5.0 cm. at the three o'clock position. The wound had 80 percent granulation (new fissue), 20 percent muscle and fascia (thin casing of connective tissue which holds muscle in-place), and moderate serous exudate (clear, thin, and watery fluid), R28's stage IV pressure wound to her left ischium measured 1.0 cm. x 1.0 cm. x 1.5 cm with abnormal granulation present within the wound margins. R28's stage IV pressure wound to her right ischium measured of 6.0 cm. x 0.8 cm. x 0.0 cm. x 1.0 cm with 100 percent granulation present. Recommendations included offloading the wound and repositioning per facility protocol. R28 may be up for two hours in their chair and one hour after a two-hour break. Review of R28's November 2021 Task Record, revealed no transferring/bed mobility was not documented for 46 of 87 opportunities. There were no documented for 2 of 3 opportunities. There were | VICTORY | / HEALTH & REHABI | LITATION CENTEL | | | | |
| hospitalized from 10/1/21, to 10/20/21 due to severe sepsis secondary to a decubitus sacral wound abscess (collection of puss related to infection) and osteomyelitis. Additionally, R28 was under observation in the hospital on 11/24/21, related to chest pain. R28's Wound Physician Progress Note written by medical doctor (MD)-C dated 11/18/21, revealed the following: - R28's stage IV sacral pressure wound measured 3.5 centimeters (cm.) x 3.0 cm. x 2.0 cm. with undermining of 5.0 cm. at the three o'clock position. The wound had 80 percent granulation (new tissue), 20 percent muscle and fascia (thin casing of connective tissue which holds muscle in-place), and moderate serous exudate (clear, thin, and watery fluid). R28's stage IV pressure wound to her left ischlium measured 1.0 cm. x 1.5 cm with abnormal granulation present within the wound margins. R28's stage IV pressure wound to her right ischlium necessariem of the relative the sum of the right ischlium necessariem of the relative the sum of the right ischlium necessariem of the relative the sum of the right ischlium necessariem of the relative the sum of the right ischlium necessariem of the relative the sum of the right ischlium necessariem of the right ischlium necessariem of the relative the sum of the right ischlium necessariem of the right ischlium nec | PREFIX | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO | LD BE | COMPLETE |
| Review of R28's Weekly Skin Check Progress | 2 900 | hospitalized from 1 severe sepsis secon wound abscess (coinfection) and osted was under observa 11/24/21, related to R28's Wound Physmedical doctor (ME the following: R28's stage IV sameasured 3.5 cent cm. with underminio'clock position. The granulation (new tis fascia (thin casing holds muscle in-plaexudate (clear, thin stage IV pressure of the measured 1.0 cm. abnormal granulation margins. R28's staright ischium measured 1.0 cm. abnormal granulation and repositioning pobe up for two hours after a two-hour bream of R28's Norevealed no transfer documented for 46 were no documented for 20 no documented reference in the second | 0/1/21, to 10/20/21 due to ondary to a decubitus sacral offection of puss related to omyelitis. Additionally, R28 ation in the hospital on ochest pain. Sician Progress Note written by 0)-C dated 11/18/21, revealed acral pressure wound imeters (cm.) x 3.0 cm. x 2.0 mg of 5.0 cm. at the three are wound had 80 percent assue), 20 percent muscle and of connective tissue which ace), and moderate serous and watery fluid). R28's wound to her left ischium action and watery fluid). R28's wound to her left ischium action present within the wound age IV pressure wound to her ured 0.8 cm. x 0.8 cm. x 1.0 mt granulation present. Included offloading the wound are facility protocol. R28 may as in their chair and one hour eak. December 2021 Task Record, erring/bed mobility was not of 87 opportunities. There ed refusals. | | | | |

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Minnesota Department of Health STATE FORM

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|--------------------------|--|-------|--------------------------|
| | | 00166 | B. WING | | 12/0 |) 2/2021 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | | STATE, ZIP CODE | , | |
| VICTOR | Y HEALTH & REHABIL | HAHON CENTEL | AVENUE NO POLIS, MN 5 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 900 | notes revealed: - 11/19/21, at 3:50 p turning and repositi coccyx wound. The assessment of R28 - No additional docu when requested, fo 11/1/21, 11/8/21, ar During a continuous 11/29/21, from 8:30 noted to be laying fl pillow to the right of closed, and she wa called out to staff fo was moaning, "oucl out for help and sta a.m., licensed pract approached and ad repositioned since t began at 8:30 a.m. a nursing assistant. no staff entered R2 R28 who was callin and 13 minutes had During an observat LPN-B provided wo reported she had po when repositioned t wound care. R28's completely saturate which also soaked product and the she was also observed electrocardiogram (which were remove Zoll electrodes mus since her emergence | o.m. indicated R28 was on a oning program and had a progress note lacked 's wound. umentation was provided, r skin assessments on a 11/22/21. s observation conducted on a.m. to 11:43 a.m. R28 was at on her back, in bed, with a her bed. R28's eyes were s noted to be moaning and or help. At 10:30 a.m., R28 h." At 11:43 a.m., R28 called ted she had pain. At 11:44 tical nurse (LPN)-C was vised R28 had not been the continuous observation LPN-C stated she would notify. Throughout the observation, 8's room, nor responded to g out periodically. Three hours a passed. ion on 11/29/21, at 10:25 a.m. und care to R28. R28 ain and noted facial grimacing to her left side and throughout dressing was noted to be ad with bloody red drainage through to R28's incontinence set below her. Further, R28 | 2 900 | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE A. BUILDING: | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 00166 | B. WING | | | C 02/2021 |
| | PROVIDER OR SUPPLIER Y HEALTH & REHABII | ITATION CENTEL 512 49TH | DDRESS, CITY, S AVENUE NO POLIS, MN 55 | | · | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY) | IOULD BE | (X5) COMPLETE DATE |
| 2 900 | the sacral, right, an wounds. LPN-B the Vashe solution on graphs and right wounds. The gauze with Vashe solution the gauze was remalginate to R28's sapressure wounds. To cut round and rough did not cover the erwound. LPN-B therfoam dressings. Im dressing change LF aware the gauze no Vashe solution or the needed to cover the During an interview assistant director of started a performar wound care and as concerns regarding assessed, staff role providing wound caprovider. The ADOI assessed by a woushe fell off the list to transferred to the e 11/24/21. During an observat the director of nursing paceral and right and | d left ischium pressure in poured a small amount of gauze and placed the gauze on the gauze and placed the gauze on the gauze and placed the gauze on the gauze and left ischium pressure is was not completely saturated. After roughly five minutes, oved and LPN-B applied silver acral, right, and left ischium the piece silver alginate was half 1.5 inches in diameter and accovered R28's wounds with a mediately following the PN-B stated she was not eeded to be saturated with the silver alginate dressing | | | | |
| | product. The DON had a large copious | moved an incontinence removed the dressings which amount of yellow/brown age with blood which soaked | | | | |

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| 00166 B. WING C 12/02/202 | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | | |
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| | | | 00166 | | B. WING | | | - |
| NAME OF PROVIDER OR SUPPLIER VICTORY HEALTH & REHABILITATION CENTEI VICTORY HEALTH & REHABILITATION CENTEI STREET ADDRESS, CITY, STATE, ZIP CODE MINNEAPOLIS, MN 55430 | | | | 512 49TH | AVENUE NO | PRTH | | |
| PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP | PREFIX (EACH DEFICIENC | RÉFIX | (EACH DEFICIENCY MUST BE PRECEDED BY | / FULL | PREFIX | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE | I SHOULD BE | (X5) COMPLETE DATE |
| through the dressing. The DON cleansed the outside of the sacral pressure wound and applied Vashe soaked gauze to R28's wound beds for five minutes. The DON then removed the gauze and inserted silver alginate into R28's wounds. The silver alginate did not cover the entire wound bed where undermining was located. The DON then applied a foam dressing. During an interview on 12/1/21, at 1:45 p.m. the director of nursing (DON) stated when she observed R28's dressing change on 11/30/21, it appeared wound care was not completed as ordered. She confirmed the silver alginate dressing did not cover R28's entire wound bed, as directed, and fluid had saturated through R28's dressing and onto R28's incontinence product. The DON described the drainage as bloody discharge and stated R28's wound bed lacked granulation upon her wound assessment today which was noted on previous assessments. The DON confirmed R28's wound had worsened and included several reasons which included weekly skin checks not being completed, lack of timely repositioning, and no consistent wound care. The DON also stated R28 had stool on her incontinent product and sheet when wound care was completed on 11/30/21, and staff needed to ensure R28 was kept clean. Further, the DON stated staff were not reporting to the nurse when bandages became soiled and needed to be changed. During an observation on 12/2/21, at 12:00 p.m. MD-C, the ADON, and LPN-D provided wound care to R28. LPN-D assisted R28 reposition to her left side. R28 expressed pain to MD-C and had facial grimaging, The ADON removed R28's | through the dressin outside of the sacr Vashe soaked gau five minutes. The I and inserted silver The silver alginate bed where undern then applied a foar During an interview director of nursing observed R28's drappeared wound cordered. She confideresing did not coas directed, and flu R28's dressing and product. The DON bloody discharge a lacked granulation today which was not The DON confirmed and included seven weekly skin checks timely repositioning care. The DON also incontinent product was completed on ensure R28 was ke stated staff were not bandages became changed. During an observation of R28. LPN-lar left side. R28 experience of R28 lPN-lar left side. | the over the | through the dressing. The DON cleanse outside of the sacral pressure wound at Vashe soaked gauze to R28's wound be five minutes. The DON then removed the and inserted silver alginate into R28's worked the silver alginate into R28's worked where undermining was located. The bed where undermining was located. The then applied a foam dressing. During an interview on 12/1/21, at 1:45 director of nursing (DON) stated when so observed R28's dressing change on 11 appeared wound care was not complete ordered. She confirmed the silver alginatesing did not cover R28's entire wou as directed, and fluid had saturated through the silver alginatesing did not cover R28's incontinged product. The DON described the drainabloody discharge and stated R28's woul lacked granulation upon her wound asset today which was noted on previous asset today which was noted on previous asset The DON confirmed R28's wound had and included several reasons which incompleted incontinent product and sheet when wo was completed on 11/30/21, and staff in ensure R28 was kept clean. Further, the stated staff were not reporting to the nubandages became soiled and needed to changed. During an observation on 12/2/21, at 12 MD-C, the ADON, and LPN-D provided care to R28. LPN-D assisted R28 repositioner left side. R28 expressed pain to MD | nd applied eds for the gauze wounds. tire wound the DON p.m. the she /30/21, it ed as ate and bed, bugh ence age as and bed essment essments. worsened sluded d, lack of wound bol on her und care are deeded to be DON arse when to be 2:00 p.m. wound sition to D-C and | 2 900 | | | |

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| | NT OF DEFICIENCIES NOF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | LE CONSTRUCTION | | SURVEY PLETED |
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| | | | A. BUILDING | : | | 0 |
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| NAME OF | PROVIDER OR SUPPLIER | STREET | ADDRESS, CITY, | STATE, ZIP CODE | | |
| VICTOR | Y HEALTH & REHABI | I II A II ON CENTEL | H AVENUE NO APOLIS, MN 5 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETE DATE |
| 2 900 | right and left ischiu small amount of lig on her incontinence noted on R28's skir sacral wound. The the skin with wound R28's wounds and alginate were noted told the ADON and applicator to asses pieces of silver alginserted Vashe soabeds for five minute gauze and complet wounds with silver then covered with a stated to the ADON piece of alginate we covered the entire healing. MD-C also completely. Immediately followinterviewed and stated to the ADON piece of alginate we covered the entire healing. MD-C also completely. Immediately followinterviewed and stated to the amount of tunn worsening tunnelin repositioned or not hours. MD-C stated deterioration include continuity of wound MD-C stated during in her incontinence on R28's skin wher MD-C stated she e reposition R28 eve wheelchair cushion | m pressure wounds. R28 had ht brown colored stool noted a product. Stool was also noughly three inches from the ADON proceeded to cleanse dicleanser. MD-C assessed additional pieces of silver din the sacral wound. MD-C LPN-D to use a cotton tipped in the wound and ensure all inate were removed. MD-C aked gauze into R28's wound es. MD-C hen removed the fely covered R28's pressure alginate. The wounds were a foam dressing. MD-C then I and LPN-D to ensure a full as used so it completed wound bed to promote proper instructed staff to offload R2 ago. R28's sacral wound had when she had assessed R28's ago. R28's sacral pressure ments increased in length an eling. MD-C attributed | se s s s s s s s s s s s s s s s s s s | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
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| | | 00166 | B. WING | | 12/0 |) 2/2021 |
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| VICTOR | / HEALTH & REHABIL | ITATION CENTEL | AVENUE NO | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 900 | Continued From pa | ge 17 | 2 900 | | | |
| | written by MD-C da following: - R28's stage IV sameasured 3.5 cm. Serous excaudate vislough (dead tissue Further, the wound measured 5.5 cm at 4.5 cm. at the nine at the 12 o'clock pohad "deteriorated" serous excaudate vislough (dead tissue further, the wound measured 5.5 cm at 4.5 cm. at the nine at the 12 o'clock pohad "deteriorated" serous wound was devitalized tissue (rem. | nd Physician Progress Note ted 12/2/21, revealed the cral pressure wound 4.0 cm. x 1.5 cm. Moderate was noted with 10 percent e) and 90 percent granulation. had undermining which to the three o'clock position, o'clock position, and 7.5 cm. sition. R28's sacral wound since her last visit on 11/18/21. lebrided of 1.4 cm. of non-viable) at a depth of 1.6 Pressure Injury Treatment to provide care of existing | | | | |
| | (undated) directed to provide care of existing pressure injuries and the prevention of additional injuries. Staff were to review the residents care plan and assess for any special needs of the resident, pressure injury care, current support surfaces, and status of the injury. | | | | | |
| | director of nursing (review and revise p prevention and trea could then educate and procedures. As monitoring consiste developed, with the | CHOD OF CORRECTION: The (DON), or designee, could olicies on pressure ulcer tment. The DON, or designee, staff on the facility's policies system for evaluating and ent implementation could be results of these audits being ty's Quality Assurance ew. | | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: Twenty-one | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | (X2) MULTIPLE CONSTRUCTION (X3) DATE OF CONTRUCTION (X3) DATE OF CONTRU | | | |
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| NAME OF | PROVIDER OR SUPPLIER | STREET | ADDRESS, CITY, | STATE, ZIP CODE | | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 920 | Continued From pa | ge 18 | 2 920 | | | |
| 2 920 | MN Rule 4658.0525 | 5 Subp. 6 B Rehab - ADLs | 2 920 | | | 1/10/22 |
| | comprehensive reshome must ensure B. a resident who activities of daily livi | is unable to carry out ing receives the necessary n good nutrition, grooming, | | | | |
| | by: Based on observati review, the facility fa hygiene was provid | ent is not met as evidenced on, interview, and document ailed to ensure assistance wited for 1 of 3 residents (R28) t upon staff for activities of | h | Corrected | | |
| | Findings include: | | | | | |
| | R28 had diagnoses arthritis (causes pa | ecord dated 12/2/21, indicates which included rheumatoid in, swelling, stiffness, and los and chronic pain syndrome. | | | | |
| | 10/27/21, indicated and had no docume was totally depende transfers, toilet use had impairments of | imum Data Set (MDS) dated R28 was cognitively intact ented rejection of care. R28 ent of two staff for bed mobilit, and personal hygiene. R28 both upper and lower always incontinent of bowel | | | | |
| | an ADL self-care de knee amputations, the spine connects weakness, and rhe | red 5/2/21, identified R28 had eficit related to bilateral above a sacral wound (area where to the lower half of the body) umatoid arthritis. Staff were assistance with all hygiene | | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
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| | | 00166 | B. WING | ···· | | C 02/2021 |
| | PROVIDER OR SUPPLIER Y HEALTH & REHABIL | ITATION CENTER 512 49TH | DRESS, CITY, S AVENUE NO POLIS, MN 58 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETE DATE |
| 2 920 | cares, assist with to Review of R28's AE 11/30/21, indicated 11/30/21, staff docucompleted for 16 of no documented refinospitalized on 11/2 Review of R28's AE 12/2/21, indicated for were no documented. During an observat R28 was observed a pillow slightly und fingernails were roubrownish/black resifingernails. R28's shands. R28's gums with breath had an tongue was coated thick film. During an observat R28 laying in bed a nursing assistant (N care or oral care the NA-A stated the everoral cares and nail needed to be cut or underneath. During an interview licensed practical n responsibility of nur cares. She stated a staff of the care R2 | bileting, bathing, and dressing. DL Task Record dated from 11/1/21, through mented hygiene was 87 opportunities. There were usals and R28 was 24/21. DL Task Record Record dated from 12/1/21, staff documented 1 of 3 opportunities. There | 2 920 | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE COMPI | SURVEY LETED | |
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| | | 00166 | B. WING | | 12/0 |) 2/2021 |
| | PROVIDER OR SUPPLIER Y HEALTH & REHABIL | ITATION CENTER 512 49TH | DRESS, CITY, S AVENUE NO POLIS, MN 58 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 920 | R28's fingernails re long with browning/ During an interview stated no one had o provided oral cares sometime the previpreviously brushed able to do it on her would like to have had cares provided. During an interview assistant director of was unaware oral of R28. During an interview director of nursing an interview director of nursing (heard of R28 refusinursing assistants shygiene care and dexpectation was for completed every shistated she felt there complete cares, but did not always want The DON confirmed were long. Facility policy titled (ADL's) (undated) of unable to carry out receive services to grooming, and personners. | ge 20 fon on 12/1/21, at 9:39 a.m. mained roughly two inches black residue underneath. on 12/1/21, at 10:00 a.m. R28 cleaned her fingernails or for many days; maybe ous week. R28 stated she her teeth daily when she was own. R28 expressed she her nails cleaned and oral on 12/1/21, at 1:45 p.m. the finursing (ADON) stated she ares were not provided to on 12/1/21, at 1:42 p.m. the DON) explained she had not ng cares. The DON stated should provide daily personally ocument refusals. Her personal hygiene cares to be ift and as needed. The DON was enough staff to the facility culture was nurses to help nursing assistants. It is to help nursing assistants. It is the facility culture was nurses to help nursing assistants. It is the facility culture was nurses to help nursing assistants. It is the facility culture was nurses to help nursing assistants. It is the facility culture was nurses to help nursing assistants. It is the facility culture was nurses to help nursing assistants. It is the facility culture was nurses to help nursing assistants. It is the facility culture was nurses to help nursing assistants. It is the facility culture was nurses to help nursing assistants. It is the facility culture was nurses to help nursing assistants. It is the facility culture was nurses to help nursing assistants. It is the facility culture was nurses to help nursing assistants. It is the facility culture was nurses to help nursing assistants. It is the facility culture was nurses to help nursing assistants. | | | | |

Minnesota Department of Health

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| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| | | | | | С | |
| | | 00166 | B. WING | | 12/0 | 2/2021 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| VICTORY | ' HEALTH & REHABII | ITATION CENTEL | AVENUE NO OLIS, MN 5 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 920 | Continued From pa | ge 21 | 2 920 | | | |
| | review applicable p ensure residents ar care with personal | (DON), or designee, could rocedures and policies to re provided oral care and nail hygiene/grooming in a timely ate staff and audit to ensure e. | | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: Twenty-one | | | | |
| 2 930 | MN Rule 4658.0529 Nasogastric, Gastro | 5 Subp. 7 B. Rehab - ostomy tubes | 2 930 | | | 1/10/22 |
| | Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: | | | | | |
| | gastrostomy tube o appropriate treatme aspiration pneumor dehydration, metab | who is fed by a nasogastric or r feeding syringe receives the ent and services to prevent nia, diarrhea, vomiting, olic abnormalities, and lcers and to restore, if eding function. | | | | |
| | by: Based on observati review, the facility f was administered a (R28) who received Findings include: | ent is not met as evidenced on, interview, and document ailed to ensure a tube feeding as ordered for 1 of 2 residents I a tube feeding. | | Corrected | | |

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Minnesota Department of Health STATE FORM

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | | (X3) DATE COMP | SURVEY LETED |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 930 | Continued From page 22 | | 2 930 | | | |
| | arthritis (causes pa | cluded diabetes, rheumatoid in, swelling, stiffness, and loss, and a pressure ulcer. | | | | |
| | 10/27/21, indicated | imum Data Set (MDS) dated R28 was cognitively intact. indication R28 received a tube | | | | |
| | | are area assessment (CAA) ated R28 required tube er nutritional needs. | | | | |
| | R28's care plan dated 7/13/21, indicated R28 was at risk for impaired nutrition and hydration. R28 received a tube feeding to meet her nutritional needs due to a history of dysphasia (difficulty swallowing) and history of aspiration pneumonia. The care plan included several interventions including providing vitamin and mineral supplements, water flushes, and feedings. | | | | | |
| | directed staff to pro flushes every four h plastic tube placed abdomen into the n intestine) and Isoso mL per hour for 12 | pary Report dated 11/30/21, wide 100 milliliter (mL) water nours through a j-tube (soft, through the skin of the nidsection of the small purce (nutrition formula) 100 hours per day, as tolerated. as to be started at 10:45 a.m. 0:45 p.m. | | | | |
| | R28's Isosource tul on a pole and the for Isosource formula I remaining in the bo the Isosource form | ion on 11/29/21, at 3:00 p.m. be feeding formula was hung beeding pump was shut off. The bottle had 700 mL of solution ttle. The tubing connected to ula was hung over the pole to R28. The Isosource formula a date/time | | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|--------------------------|--|--------|--------------------------|
| | | 00166 | B. WING | ···· | 12/0 |) 2/2021 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | • | |
| VICTOR | Y HEALTH & REHABIL | I HAHON CENTEL | AVENUE NO POLIS, MN 5 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | JLD BE | (X5) COMPLETE DATE |
| 2 930 | Continued From page 23 | | 2 930 | | | |
| | R28 was observed was at a 25-to-30-d connected to the tubottle of Isosource Dried formula was a feeding and 700 ml Isosource bottle. At nurse (LPN)-C was did not disconnect t LPN-C stated it approximates to the confirmed the tubin formula had dried seeding and R28's phymissed tube feeding given to restart the hour on/off cycle. | ion on 11/30/21, at 7:25 a.m. sleeping in her bed. R28's bed legree angle, and she was not be feeding at this time. The formula lacked a date/time. noted on the end of the tube L of formula was noted in the tar:26 a.m. licensed practical interviewed and stated she the tube feeding from R28. Deared evening shift did not tube feeding. LPN-C ag connected to the Isosource substance on the end. Itted 11/30/21, at 11:07 a.m. Visician was notified of the g (11/29/21) and an order was tube feeding and follow a 12 | | | | |
| | R28 was laying in b connected to the tu LPN-C confirmed s | ion on 11/30/21, at 2:25 p.m. bed and awake. R28 was not be feeding. At 2:28 p.m. he did not complete R28's the shift as she was busy. | | | | |
| | | ion on 11/30/21, at 4:00 p.m. onnected to the tube feeding. | | | | |
| | medical doctor (MD and provided a verk order, to immediate and monitor for der had been multiple owhich orders were directed. MD-B stat | on 11/30/21, at 9:30 a.m. D)-B stated he assessed R28 cal order, and later signed an ely resume R28's tube feeding hydration. MD-B stated there occasions at the facility in not followed, or started, as ted not starting R28's tube of tially cause harm and | | | | |

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STATE FORM 6899 CRPT11 If continuation sheet 24 of 35

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING: | | | X3) DATE SURVEY COMPLETED | |
|--|--|---|---|--|------------------------------|--------------------------|
| | | 00166 | B. WING | | | C 02/2021 |
| | PROVIDER OR SUPPLIER Y HEALTH & REHABIL | ITATION CENTEL 512 49TH | DRESS, CITY, S AVENUE NO OLIS, MN 5 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETE DATE |
| 2 930 | expected the facility During an interview assistant director of tube feeding did no on 11/30/21. The Al immediately start R reported the incider During an interview director of nursing (staff to follow order and nursing superv should had restarte instructed to do so DON stated R28 we without receiving nu A progress note dat indicated MD-B was feeding. Facility policy titled Precautions (undate responsible for prepadministering etern trained, qualified, a responsibilities. Fur date, time, and initia hung and administer SUGGESTED MET director of nursing (review applicable p ensure residents ar ordered. The DON, educate staff and in to ensure ongoing of | on 12/1/21, at 1:43 p.m. the foursing (ADON) stated R28's tegt restarted until 10:45 p.m. DON stated she told LPN-C to 28's tube feeding and at to MD-B. on 12/1/21, at 1:45 p.m. the (DON) stated she expected is provided by the physician isor. The DON stated LPN-C d R28's tube feeding when by the ADON on 11/30/21. The ent more than 24 hours utrition. ted 12/1/21, at 6:41 p.m. is notified R28 missed a tube Enteral Feedings Safety ed) directed all staff paring, storing, and all nutrition formulas will be and competent of ther, staff were directed to all the label when formula was ered. THOD OF CORRECTION: The (DON), or designee, could recedures and policies to be receiving tube feedings as or designee, could then implement a monitoring system | 2 930 | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE OF COMPI | | | SURVEY LETED |
|--|--|---|--|---|------|--------------------------|
| | | 00400 | B. WING | | C | |
| | | 00166 | | | 12/0 | 2/2021 |
| NAME OF F | PROVIDER OR SUPPLIER | | DRESS, CITY, S AVENUE NO | STATE, ZIP CODE | | |
| VICTORY | HEALTH & REHABIL | ITATION CENTEL | OLIS, MN 5 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 930 | Continued From page 25 | | 2 930 | | | |
| | (21) days. | | | | | |
| 21475 | MN Rule 4658.1005 Subp. 1 Social Services: General Requirements | | 21475 | | | 1/10/22 |
| | home must have ar department or prog related social servic nursing home must collaborate with out who is in need of ac | I requirements. A nursing norganized social services ram to provide medically ces to each resident. A make referrals to or reside resources for a resident additional mental health, or financial services. | | | | |
| | This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide comprehensive assistance with potential discharge planning for 1 of 1 resident (R500) who had ongoing allegations of sexually inappropriate behavior towards female residents (R501). | | | Corrected | | |
| | Findings include: | | | | | |
| | 11/12/21, identified impairment and wa activities of daily liv | nimum Data Set (MDS) dated R500 had a severe cognitive s independent with all ing (ADLs). R500's diagnoses d cognitive decline and alcohol | | | | |
| | R500 was, "At risk of to] poor impulse condementia, level 1 sealso included, "On 8 | evised on 9/23/21, identified of abusing others r/t [related ntrol, alcohol induced ex offender." The care plan 8/27/21 resident accused of resident inappropriately near | | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|--------------------------------------|---|-------------------------------|--------------------------|
| | | 00166 | B. WING | | | C)2/2021 |
| | PROVIDER OR SUPPLIER Y HEALTH & REHABIL | ITATION CENTER 512 49TH | DRESS, CITY, S AVENUE NO POLIS, MN 5 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | ULD BE | (X5) COMPLETE DATE |
| 21475 | south hall." On 9/23 care plan instructed female residents," alternative placeme making sexual gest redirect him back to enter a female reside immediately," [R500] besides South hall "[R500] will not enter from female resider inappropriate behave. A Behavior Contract outlined, "Boundarid inappropriate behave. Refrain from touch if they request a huranger resident in appropriate behave. Refrain from entered when in common sexual comments of the progress note data included, "Met with with female resident recommendations from the progress of the progress of the progress of the progressed understate the progressed understate best interest." A Mental Health Progression of the progressed understate the progressed un | 8/21, "accused of kissing." The distaff to, "Redirect away from Assist in looking [for] ent," If staff hear [R500] cures tell him to stop and on his room," "If staff see [R500] dent's room, remove resident of his not to be in any other hall without supervision," and er north hall, will stay away not related to allegations of vior. It signed by R500 on 11/13/20, hes related to allegations of vior: Ining any female resident, even g from you. Ining any female resident's rooms. Is areas refrain from making or gestures. Ited 9/3/21, at 3:04 p.m. Ited 9/3/21, at 3:04 p.m. Ited 9/3/21, at 3:04 p.m. | | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | (X3) DATE COMP | SURVEY LETED | |
|---|--|--|---------------------|---|-----------------|--------------------------|
| | | 00166 | B. WING | | 10/0 | |
| | | 00166 | | | 12/0 | 2/2021 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| VICTORY | / HEALTH & REHABIL | ITATION CENTEL 512 49TH | AVENUE NO | ORTH | | |
| VICTOR | I HEALIH & REHABIL | MINNEAP | OLIS, MN 5 | 5430 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE |
| 21475 | Continued From pa | ge 27 | 21475 | | | |
| | ambivalent about the on the location." | nis, but agreeable depending | | | | |
| | R501 stated that R5 physical with her ar to do that." R501 st boobs. I don't like the Additionally, R500 s and she did not wardon't feel good about During an interview R500 stated he tho | on 11/29/21, at 11:39 a.m. ught R501 was a "Nice lady" O denied touching or kissing | | | | |
| | social worker (SW) was a level 1 sex of "couple" of reports of inappropriate behave during his stay at the allegations, R500 with different hallway the educated R500 and other. SW-A stated placement in an all-unsuccessful. This placement at one a facility approximate facility was unable to status as a sex offer additional inquiries placement. SW-A scare conference so R500's daughter to | on 11/29/21, at 1:00 p.m. A stated she was aware R500 ffender and there had been a of R500 displaying sexually vior directed towards R501 in the nursing home. Due to the vas moved to a room in a stan R501 and staff were if R501 were not to touch each she attempted to find R500 included inquiring about a liternative skilled nursing ly two months ago, but the concept R500 due to his liternative that a confirmed nowere made for alternative tated R500 was "due for a on" and she could talk to see if they were open to oning to an assisted living the confirmed on the could talk to see if they were open to oning to an assisted living the confirmed on the could talk to see if they were open to oning to an assisted living the confirmed in the could talk to see if they were open to oning to an assisted living the confirmation in the could talk to see if they were open to oning to an assisted living the confirmation in the could talk to see if they were open to oning to an assisted living the confirmation in the could talk to see if they were open to oning to an assisted living the confirmation in the could talk to see if they were open to oning to an assisted living the confirmation in the confirm | | | | |

Minnesota Department of Health

STATE FORM 6899 CRPT11 If continuation sheet 28 of 35

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|---|---|--|-----------------------------------|--------------------------|
| | | 00166 | | B. WING | | | C 02/2021 |
| | PROVIDER OR SUPPLIER Y HEALTH & REHABII | ITATION CENTER 5 | 12 49TH | ORESS, CITY, S AVENUE NO OLIS, MN 5 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATIO | | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| 21475 | During an interview director of rehabilita "be reasonable" to an alternative level or a group home condependence with the administrator and (ADON) the administrator and (ADON) the administrative placements facility. The ADON team had agreed to ongoing risk of inappropriate to a see thought referrals to to multiple all-male declined at each factor and the country of the administrator in the country of the administrator in the country of t | on 11/30/21, at 4:07 p. ation services stated it v consider R500 for trans of care such as assiste onsidering R500's | would sfer to ed living .m. with nursing y had pursing ale nary tigate ith the or en sent been istered e to ed living f SW-A navior on to be cy be e safety to the c" | 21475 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | | E SURVEY IPLETED | |
|---|--|---|-------------------------|---|---------------------|--------------------------|
| | | | | | С | |
| 00166 | | B. WING | | 12/0 | 2/2021 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| VICTORY | / HEALTH & REHABII | ITATION CENTEL | AVENUE NO OLIS, MN 5 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 21475 | Continued From pa | ge 29 | 21475 | | | |
| | monitoring systems compliance and rep Assurance Commit | oort the findings to the Quality | | | | |
| 21545 | MN Rule 4658.1320 A.B.C Medication Errors | | 21545 | | | 1/10/22 |
| | percent as described Guidelines for Code 42, section 483.25 the State Operation Surveyors for Long incorporated by refe purposes of this pa (1) a discrepair prescribed and what administered to rese (2) the administered to reserror. A significant (1) an error discomfort or jeopal safety; or (2) medication error requires the medication error coprecipitate a reoccut toxicity. All medicate prescribed. An incommercer report must be that occurs. Any significant code. | ast ensure that: on error rate is less than five ed in the Interpretive e of Federal Regulations, title (m), found in Appendix P of as Manual, Guidance to -Term Care Facilities, which is erence in part 4658.1315. For ort, a medication error means: ncy between what was at medications are actually idents in the nursing home; or estration of expired any significant medication medication error is: which causes the resident ordizes the resident's health or on from a category that usually ation in the resident's blood to cific blood level and a single and alter that level and currence of symptoms or ions are administered as ident report or medication are filed for any medication error guificant medication errors or must be reported to the | | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|---|--|------|--------------------------|
| | | 00166 | B. WING | | 12/0 |) 2/2021 |
| _ | PROVIDER OR SUPPLIER / HEALTH & REHABIL | ITATION CENTER 512 49TH | DRESS, CITY, S AVENUE NO OLIS, MN 5 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 21545 | physician or the phyresident or the resident or the residesignated represemust be made in the C. All medication prescribed. An incireport must be filed occurs. Any signification resident reactions rephysician or the phyresident or the residesignated represemust be made in the | ge 30 ysician's designee and the dent's legal guardian or ntative and an explanation e resident's clinical record. Ons are administered as dent report or medication error for any medication error that cant medication errors or nust be reported to the ysician's designee and the dent's legal guardian or ntative and an explanation e resident's clinical record. | 21545 | | | |
| | review, the facility facility facility facility medication during the facility medication and 30% (percent). Findings include: R28's Admission Races and profession and p | on, interview, and document ailed to ensure medications in accordance with physician onal standards of practice for 28) observed to receive he survey. This resulted in a administration error rate of ecord dated 12/2/21, indicated cluded diabetes, pressure on (area where the spine er half of the body), and d left leg above knee. dated 7/26/21, indicated R28 dication crushed and given | | Corrected | | |
| | with applesauce for easy swallowing. Review of R28's November 2021 Medication | | | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MI II TIPI | E CONSTRUCTION | (X3) DATE | SURVEY | |
|---|---|--|----------------|---|--------------------|------------------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING: | | COMPLETED | | |
| | | | | С | | |
| 00166 | | B. WING | | | <i>)</i> 2/2021 | |
| | | | | | 12/0 | /Z/ZUZ I |
| NAME OF I | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| VICTORY | / HEALTH & REHABII | ITATION CENTEL | AVENUE NO | | | |
| | | | OLIS, MN 5 | | | |
| (X4) ID PREFIX | | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL | | (X5) COMPLETE |
| TAG | | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROI | | DATE |
| | | | | DEFICIENCY) | | |
| 21545 | Continued From pa | ge 31 | 21545 | | | |
| | Administration Rec | ord (MAR), indicated staff | | | | |
| | | the following medications by | | | | |
| | mouth: | (| | | | |
| | | (antibiotic). Give one tablet by | | | | |
| | mouth two times a | nilligram tablet. Give 100 | | | | |
| | | h every 12 hours for bone and | | | | |
| | joint infection. | | | | | |
| | - Morphine sulfate (| | | | | |
| | | ablet 15 mg. Give one tablet by | | | | |
| | | daily for chronic pain. | | | | |
| | 20 mg twice daily. | tablet (treats heartburn). Give | | | | |
| | | 250mg/5mL. Give 300 mg (6 | | | | |
| | | nouth two times daily for | | | | |
| | neuropathic pain | , | | | | |
| | The November 202 | 1 MAR further indicated the | | | | |
| | | ns were to be administered via | | | | |
| | g-tube (tube feeding | | | | | |
| | | id) 5 mg tablet. Give one | | | | |
| | tablet daily via g-tub | tablet. Give 1 tablet via g-tube | | | | |
| | daily for high blood | | | | | |
| | | tablet. Give 1 tablet via g-tube | | | | |
| | every Tuesday for o | | | | | |
| | | e. Give 50 mg via g-tube two | | | | |
| | times daily for high | blood pressure. | | | | |
| | On 11/30/21 at 0:1 | 3 a m. licensed practical pures. | | | | |
| | On 11/30/21, at 9:13 a.m. licensed practical nurse (LPN)-C was observed preparing medications for | | | | | |
| | R28 which included | | | | | |
| | | | | | | |
| | - Cefuroxime Axetil | | | | | |
| | - Amlodipine 5 mg | | | | | |
| | - Duloxetine 20 mg | | | | | |
| | - Doxycycline 100 n | | | | | |
| | Morphine sulfate extended-release 15 mg Famotidine 20 mg | | | | | |
| | - Metoprolol Tartrate 50 mg | | | | | |
| - Gabapentin 6 mL 250mg/5mL give 300 mg | | | | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | (X3) DATE COMP | SURVEY LETED | | | |
|---|---|------------|---------------------|-------------------|--|--|--|--|
| | | | | | С | | | |
| 00166 | | B. WING | | | 2/2021 | | | |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | | | |
| VICTORY | VICTORY HEALTH & REHABILITATION CENTEI 512 49TH AVENUE NORTH | | | | | | | |
| VICTOR | THEALITI & NETIABII | MINNEAP | OLIS, MN 5 | 5430 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | (EACH CORRECTIVE ACTION SHOULD BE COMING PROSS-REFERENCED TO THE APPROPRIATE | | | |
| 21545 | Continued From pa | ge 32 | 21545 | | | | | |
| | - Prednisone 5 mg was not prepared as the medication was unavailable. | | | | | | | |
| | On 11/30/21, at 9:13 a.m. LPN-C was observed to crush the above noted medications and placed them in medication cups. Additionally, LPN-C poured Gabapentin 250mg/5mL into a plastic medication cup with measurement lines on the cup (with measuring lines labeled 2.5, 5, 7.5). It was unable to be determined it 6 mL of Gabapentin was in the medication cup. LPN-C then gathered supplies and went into R28's room. LPN-C connected connected the syringe to R28's g-tube and pulled back. LPN-C then flushed the G-tube, using a syringe, with water. LPN-C then mixed four medications together with water and administered in G-tube with water flush. LPN-C next administered the liquid gabapentin medication and flushed with water. LPN-C then administered the last three crushed medication mixed together with water, gave in R28's G-tube, and flushed with water. During an interview on 11/30/21, at 9:13 a.m. LPN-C stated all medications could be crushed for R28 because there was an order. LPN-C also stated she was late with medication administration and confirmed Prednisone 5 mg tablets were not available. At 9:20 a.m. LPN-C confirmed she poured gabapentin into a plastic medication cup and had estimated 6 mL. LPN-C stated she should had used a syringe, but one was not available. LPN-C stated she could had given R28 too much gabapentin it not measured accurately. Further, she knew R28 had an order to crush medications, but was not aware to order was to place the medication in applesauce and give by mouth. LPN-C stated the physicians order | | | | | | | |
| | | | | | | | | |
| should be followed and the physician should be asked if there were questions. LPN-C confirmed | | | | | | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|----------------------------|--|------------|--------------------------|
| | | A. BUILDING. | | С | | |
| 00166 | | B. WING | | | 12/02/2021 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, | STATE, ZIP CODE | | |
| VICTORY | / HEALTH & REHABII | I IIAIION CENTEL | I AVENUE NO POLIS, MN 5 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | JLD BE | (X5) COMPLETE DATE |
| 21545 | Continued From pa | age 33 | 21545 | | | |
| | all oral medications g-tube. | s were cocktailed and given via | ı | | | |
| | medical doctor (MD | on 11/30/21, at 1:55 p.m. D)-A stated he expected staff to sordered to ensure proper ef of symptoms. | | | | |
| | During an interview on 12/1/21, at 9:00 a.m. the consulting pharmacist (CP) stated staff were expected to administer medication based on the physician order. The CP stated it was best practice to use a syringe when drawing up gabapentin to ensure the dose was correct. | | | | | |
| | During an interview on 12/1/21, at 9:30 a.m. MD-B stated he expected the facility to follow medication orders as directed. If medications were ordered by mouth, then they should be given by mouth. If a resident had a change in condition, the physician should be notified and request a change or to review orders. MD-B stated the nurse should had clarified orders with the physician. | | | | | |
| | director of nursing staff passing medication, and the expected staff to endose, right medications individual had questionally as the medications via a tube feeding, considered a medicational should not estimate DON stated LPN-C | on 12/1/21, at 1:42 p.m. the (DON) stated she expected cation to check orders, check en check again. Further, she nsure the right person, right tion, right route, and right time is were administered. If an etions about an order, they administration. The DON which were crushed and giver rather than by mouth, were cation error. Further, LPN-C et a dose of gabapentin. The could need to write up and she would provide staff | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING: | | | X3) DATE SURVEY COMPLETED | |
|---|---|--|---|--|------------------------------|--------------------------|
| 00166 | | B. WING | ···· | | C 0 2/2021 | |
| | PROVIDER OR SUPPLIER Y HEALTH & REHABIL | ITATION CENTER 512 49TH | DRESS, CITY, S AVENUE NO OLIS, MN 5 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETE DATE |
| 21545 | education and guesterror. Facility policy titled Medications (undatadministering medicorders, review the ospecial needs. SUGGESTED MET The director of nurs review and/or revise medication administed designee, could the monitoring system of correctly administer physician. The qual monitor these measures | Administering Oral ed) directed the individual cation to verify physician care plan, and assess for THOD OF CORRECTION: sing (DON), or designee, could e policies related to tration. The DON, or en educate staff and develop a to ensure medication were red as ordered by the ity assurance committee could | 21545 | | | |

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